505 E. Perkins Avenue
Sandusky, OH 44870
www.CancerResources.org

Phone: (419) 626-4548
Fax: (419) 502-0222
CancerServicesPatients@gmail.com

Prescription Reimbursement

Client Name: ____________________________ **Reimbursement for the *calendar* month of:** _____________

Address: ____

Phone: __________________________________ **County:**________________________

Please attach documentation for each cancer prescription for which you are requesting reimbursement OR request a printout from your pharmacy technician.

Medication Name	Date Purchased	Out of Pocket Expenses (After insurance has paid)
Total:		**$**

Office Use Only		
Amount Approved:	**Approved for Payment:**	**Date of Approval:**