Giant Eagle Specialty Pharmacy

Phone: 1-844-259-1891
Fax: 1-877-645-4142

Please complete the form and return to:
Giant Eagle Specialty Pharmacy (#232)
600 Lindbergh Dr., Suite 300
Moon Township, PA 15108

FINANCIAL ASSISTANCE FORM

Today's Date: _____

Patient Information

Date: _____ ☐ Male ☐ Female DOB: _____

Patient's First Name: _____ Patient's Last Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Phone Number: _____ Alternate Phone Number: _____

Best E-mail Address: _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

Patient Information

What is the patient's medical condition/diagnosis relative to this application?

_____

_____

What drug/treatment is the patient being prescribed?

_____

_____

Funding Criteria Qualification

Number of people in patient's household (including patient): _____

What is the patient's total annual gross income for all household members? _____

Is patient a legal U.S. resident? ☐ Yes ☐ No Does patient have insurance coverage? ☐ Yes ☐ No

Insurance Information

Primary Insurance: _____ Primary Health Insurance Phone #: _____

Primary Health Insurance Id #: _____ Primary Health Insurance Group #: _____

Prescription Insurance: _____ Prescription Insurance Phone #: _____

Prescription Insurance Id #: _____ Prescription Insurance Group #: _____

Prescriber Information

Date Prescription Needed: _____

Physician Name (please print): _____ Contact Name: _____

Phone #: _____ Fax #: _____ NPI #: _____ Tax ID #: _____

Office Address: _____ City: _____ State: ____ ZIP: _____

State License #: _____ DEA #: _____

If you are requesting on someone's behalf, please complete the section below.

Requester Information

Requester's First Name: _____ Requester's First Name: _____

Address: _____

Primary phone #: _____ Alternate Phone Number: _____

Email: #: _____ Relationship to Patient: _____

Authorization

Requester Signature: _____ **Date:** _____

Please Print Patient Name: _____

First Name *Last Name*