Request for Medical Assistance

Member Information

Name: ____________________

Address: ____________________

City: __________ State: ______ Zip Code: ______

Home # __________ Other # __________

Number of members in family: __________

Coverage needed for:

Name: ____________________

Is this person covered on any other medical insurance plan? __________

Is this request for:

- ____ Urgent and necessary treatment
- ____ Ongoing medical condition
- ____ Prescriptions

Nature of illness: ____________________

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Prescription drugs:

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____________________ **Member Signature**

____________________ **Date**