

Patient Grant Request

This form may be completed to apply for financial assistance with items that provide medical care and quality of life for those impacted by a movement disorder. This includes and is not limited to transportation to/from appointments, copays, equipment, etc.

Please submit this request via email to info@wvmda.org or print & mail to 5432 Peaceful Ridge, Lavalette, WV 25535.

If approved, you will be contacted with further instruction. You will need to submit any & all receipts, invoices, etc as they occur.

Name:				
Date:	_			
Address:				
Phone number:				
Email:				
Amount requested: \$				
Sponsoring member of V	VVMDA:			_
Insurance Company:				-
Member/Group number :	<u> </u>			-
Insurance Phone numbe	r :			
Number of People in Hou	ısehold:			
Annual Household Incom	ne: (mark one	e)\$0-50,000	;	\$50,001-100,000
		\$100,000-150),000	>\$150,000
Prior year's annual out o	f pocket heal	thcare cost: (mark o	ne)	
\$0-2,500\$2,50	00-5,000	\$5,000-7,500	_\$7,500-10,0	00>\$10,000
Is the request for a future	e expense an	d/or reimbursement	for a prior ex	pense? (Mark one)
Past Expense reimb	ursement	Future expense	only	Both prior & future

Provide a brief description of the requested item and/or service. Include your estimated need over the next year & how it relates to your movement disorder:					
ttach any suppo escription if nee		entation, quo	otes, etc. as w	ell as addition	nal pages of
 OFFICE USE ONL	 -Y:				
Approved	Denied	Date:			