



Butler County Request Form

Return Forms to:
Patient Assistance Services Inc.
P.O. Box 407, Marion, OH 43302

Patient Information

Name: _____

Address: _____

City: _____ Township/Village: _____

State: _____ Zip: _____ Home Phone: (____) _____

Marital Status: _____ Date of Birth: _____ S.S.# _____

The best time to call me during the workweek is in the: Morning Afternoon

Alternate Contact Information (Calls, Paperwork, & Invoices may be directed here)

Name: _____

Work Phone: (____) _____ Relationship to Patient: _____

Home Phone: (____) _____

Physician Information

Doctor #1

Doctor #2

Name: _____

Name: _____

Facility Name: _____

Facility Name: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City/St/ZIP _____

City/St/ZIP: _____

Prescription Information (Please put the prescribing doctor # with each medication)

| Doctor | Brand/Generic | Strength | Frequency |
|--------|---------------|----------|-----------|
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I've enclosed my 1040 Federal Tax return for 2002, or, if not filed taxes in 2002, a copy of my Social Security Benefit Verification Statement (SSA 1099)

Signature _____ Date: _____