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The US Oncology Network
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Patient Assistance

What is "Patient Assistance"?

"Patient Assistance" is a term used to describe a charitable organization dedicated to providing help to individuals with difficulty affording the high cost of healthcare associated with their a specific illness. These foundations offer financial assistance to eligible patients for covering certain out-of-pocket health care cost. (For example: there are specific foundations established to help with co-insurance for certain cancer drugs or blood disorders, etc)

Specific patient guidelines must be met for acceptance into these programs. Some of these guidelines include household income, insurance coverage, diagnosis, chemotherapy drugs, and available funding.

How do we help you?

When our billing specialist has determined that you may be a candidate for assistance, she will refer you to the Patient Assistance Coordinator. From here, we try and match your diagnosis and therapy plan with a foundation that may be able to help. In order to beginning the process, you will be asked to provide proof of income and diagnosis. Once all proper documentation has been obtained, we will submit your application on your behalf. From there, the foundation determines your eligibility.

It is important to note that regardless of your eligibility with patient assistance, and regardless of your status in these programs, you are still responsible for paying your co-payment. The assistance that you may or may not receive will help only with specific drugs, and not your entire balance. Please remember, you alone are responsible for your balance.

This service is not a guarantee of payment. It is simply to assist in trying to minimize your out-of-pocket expense with our office. We encourage our patients to seek out other forms of assistance as well for making payments on your balance. If you do take outside assistance, please let someone in our insurance and billing department know of your status in these organizations.

If you have any questions please do not hesitate to contact me. I look forward to working with you.

Patient Assistance Coordinator

I understand the above specifications and conditions of the patient assistance program and accept the guidelines listed above

Authorized Signature _____ Date _____/_____/_____