Patient Referral Form RX Grant Only

This form should be completed if someone has insurance (private or government plan) and is experiencing difficulty paying for their medications. Someone from Big Bend Health will contact the patient within 3 business days.

Client Information:

Client name:		Phone Number:
Type of Insurance: ☐ Medicare ☐ Private Insurance ☐ None	Client Date of Birth:	Client Primary Language: ☐ English ☐ Spanish ☐ Other:

(Provider use):

To:	Big Bend Regional Hospital District RX Grant	Fax:	432-837-3261
From:		Provider's Phone:	

(Provider use) **Medication List:**

(Provider use) **Services needed:**

☐ RX Grant	Assistance in applying for Patient Assistance Programs directly through drug manufacturers
☐ Medical case management	Assistance in coordinating and scheduling medical appointments

I (*client's name*), _____, understand that the information provided on this form will be released to Big Bend Regional Hospital District. I give my permission for this referral to be made and information to be released. I understand that this information is confidential.

_____ _____

(Client signature) (Date)