NATIONAL MARROW DONOR PROGRAM® BE ❁ THE MATCH®

Family Typing Grant – helps pay typing costs of first-degree relatives

A)

NMDP Recipient ID _____-_____-____   **Name** _____

Date of birth _____   Sex   Male   Female   Living in the U.S.   Yes   No

(Peds only) Parent/guardian name _____

Address _____

Phone number _____-_____-_____   Email address _____

B)

Indicate patient's insurance coverage for each of the following:

Typing of relatives   Covered   No coverage   Limited – explain: _____

Unrelated donor search   Covered   No coverage   Limited – explain: _____

Transplant   Covered   No coverage*   Limited – explain: _____

*If not covered for transplant, explain how transplant will be paid: _____

Primary insurance company name _____   Issuing state _____

Insurance type - check one:

　Medicaid – managed care   Medicaid – state   Medicare – Advantage   Medicare – Standard
　Private/commercial   Tricare

　Not insured: Coverage/auth pending   TC charity care   Other, explain: _____

Group number _____   Plan number _____   Individual policy number _____

C)

Specify lab for donor typing: **ARC NE**   **Histogenetics**   **Kashi Clinical Labs**   **LabCorp**

Provide the name and relationship of each <u>first-degree</u> relative for whom you are requesting a grant:

Relative 1 name: _____   **Sibling   Parent   Child**

Relative 2 name: _____   **Sibling   Parent   Child**

Relative 3 name: _____   **Sibling   Parent   Child**

Relative 4 name: _____   **Sibling   Parent   Child**

Relative 5 name: _____   **Sibling   Parent   Child**

D)

TC # _____   **TC name** _____

TC coordinator _____   Email _____

Other contact _____   Email _____