Patient Financial Assistance

The transplant center needs financial assistance for family typing or reimbursement for NMDP/Be The Match search activity (related, unrelated or patient typing)

Use the form as guidance for completing the online application. **This is not an application.**

If you have any questions, please contact our Patient Financial Assistance Team at patientgrants@nmdp.org

Your patient's NMDP Recipient ID (RID) (if applicable): _____

Select what you are requesting

- ☐ Patient or family typing
- ☐ Search activities reimbursement*

***No pre-approval is needed. Do not delay the formal search of the NMDP registry and work with your Case Manager to request identified donors/cords.** The amount awarded will vary by patient and will not exceed $20,000 per transplant for search and procurement activity not covered by insurance. We require proof of inadequate insurance. We prefer the explanation of benefits but will also accept the denial letter from the insurance company, policy indicating lack of coverage or document communication from the insurance company.*

Patient's primary insurance:

- ☐ Private/commercial/employer sponsored
- ☐ Medicare–advantage/cost
- ☐ Medicare–standard
- ☐ Medicaid–managed care
- ☐ Medicaid–state/Fee-for-service (FFS)
- ☐ Charity care
- ☐ Tricare
- ☐ Not insured
- ☐ Other, please specify: _____

Is your patient's primary insurance employer-sponsored?

- ☐ Yes, please specify employer: _____
- ☐ No

Patient's primary insurance information:
Write 'N/A' if not applicable.

Insurance company name	
Issuing state	
Insurance policy number	
Insurance plan number	
Insurance group number	

Patient's <u>secondary</u> insurance:

- ☐ My patient does not have secondary insurance
- ☐ Private/commercial/employer sponsored
- ☐ Medicare–advantage/cost
- ☐ Medicare–standard
- ☐ Medicaid–managed care
- ☐ Medicaid–state/Fee-for-services (FFS)
- ☐ Charity care
- ☐ Tricare
- ☐ Other, please specify: _____

Is your patient's <u>secondary</u> insurance employer-sponsored?

- ☐ Yes, please specify employer: _____
- ☐ No

Patient's <u>secondary</u> insurance information:
Write 'N/A' if not applicable.

Insurance company name	
Issuing state	
Insurance policy number	
Insurance plan number	
Insurance group number	
My patient does not my secondary insurance	

Indicate patient's insurance coverage

	Covered	Not covered or limited
Patient or family typing	☐	☐
Unrelated search	☐	☐
Procurement/acquisition	☐	☐
Transplant	☐	☐

Reason for lack of insurance coverage

- ☐ Coverage only for identified donor
- ☐ Currently uninsured *(patient or family typing only)*
- ☐ Lifetime or annual limit reached, please specify limit: _____
- ☐ Out of network coverage
- ☐ Pending insurance authorization *(patient or family typing only)*
- ☐ Search and procurement coverage limit reached, please specify limit: _____
- ☐ Other, please specify: _____

Payment will be made directly to the transplant center. Please confirm remit address.

First name	
Last name	
Address 1 (street address, P.O. box, company name, c/o)	
Address 2 (Apartment, suite, unit, building, floor, etc.)	
City	
State	
Zip code	

Patient or family typing ONLY:

You need to:

- Provide the relative's first name, last name and relationship to patient
- Specify name of lab for typing
  - ☐ ARC NE (covers A, B, C, DRB1 and DQB1 - LR typing)
  - ☐ HISTOGENETICS (covers A, B, C, DRB1 and DQB1 - IR typing)
  - ☐ KASHI CLINICAL LAB (covers A, B and DRB1 - IR typing)
  - ☐ LABCORP (covers A, B, C and DRB1 - IR typing)
  - ☐ I prefer to use the lab at my transplant center*

    **If the typing is done at your own lab, NMDP/Be The Match will only reimburse your transplant center $200 per typing.*

Search activity reimbursement ONLY:

You will need to:

- Attach proof of search and procurement activities that were not covered by insurance.
- Attach the corresponding NMDP invoice(s) for requested reimbursement
- Identify which donors/cords you are asking reimbursement for and what activities are associated (formal search activation/supplier activation, TOB, IDM, etc.)

Patient information:

First name	
Last name	
Address 1(Street address, P.O. box, company name, c/o)	
Address 2 (Apartment, suite, unit, building, floor, etc.)	
City	
State	
Zip code	
Phone number	
Email address	
Date of birth (mm/dd/yyyy)	

Patient ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer not to answer

Patient race: *Select all that apply.*

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Prefer not to answer
- ☐ Not listed, please specify: _____

Patient gender:

- ☐ Male
- ☐ Female
- ☐ Prefer not to answer
- ☐ Not listed, please specify: _____

Patient diagnosis: _____