Cancer Outreach Program

Deliver to hospital front desk OR
Mail to: Case Management
P.O. Box 660, Mammoth Lakes, CA 93546
phone 760-924-4211, fax 760-924-4123

Financial Reimbursement Application
Applications must be submitted within 30 days of appointment.
Please allow up to four weeks to process application.
All information on this application is CONFIDENTIAL.

Name:	Birthdate:	
Physical Address:	City/State/Zip:	
Mailing Address:	City/State/Zip:	
Main phone:	Alternate phone:	Email:
Diagnosis:	Date of diagnosis:	
Active treatment/maintenance (circle one)	Dates of medical appointments:	
Physician name and contact info:		
Are you receiving additional funding? Yes/No	If yes, from whom?	
How did you hear about us?		

Expenses are reimburseable for the day of the appointment and one day before and after for travel. Extra days require a physician's note explaining medical necessity. We can only accept original, itemized receipts for lodging up to $150 a day, food up to $50 a day *(no alcoholic beverages)* , and gas/parking fees/tolls per receipt.

	example: 2/14	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Lodging	*$150.00*							
Gas	*$45.00*							
Food	*$10.00*							
	$15.00							
	$25.00							
Daily Total	$245.00							
						Total requested:		

*Documents bolded below must be submitted to us within 30 days of the visit you are requesting reimbursement for. *Please note that this fund is available to those who work or live in Mono County. *We are currently unable to reimburse for caregiver expenses. *There is an annual limit available to each applicant of $1000 for maintenance visits or $3000 if you are in active treatement.

Please double check prior to submission - reimbursement cannot be processed without:
__ this application form __proof of cancer related appointment(s) __original, itemized receipts

I have read and understand this form. I have provided correct and complete information.

I give Mammoth Hospital permission to contact my cancer providers if additional information is needed.

Applicant signature: **Date:**

For Office Use Only:

The Cancer Outreach Committee has determined this applicant is eligible for assistance.

Board Chair Signature: Date:

Total:
Remaining: