



Xubex®
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http://www.xubex.com

Patient Assistance Program Application

Use this application form to apply for Xubex's patient assistance program. Attach prescription(s) along with completed application and mail to the address above.

Patient Information			
First Name	<input type="text"/>	Mi	<input type="text"/>
Last Name		<input type="text"/>	
Address		<input type="text"/>	
Apt.	<input type="text"/>		
City	<input type="text"/>	State	<input type="text"/>
Zip	<input type="text"/>		
DOB	<input type="text"/>	Gender	<input type="text"/>
SSNumber	<input type="text"/>		
Phone	<input type="text"/>		Alt. Phone
<input type="text"/>			
Email Address	<input type="text"/>		

Insurance Information

Name	<input type="text"/>	Bin#	<input type="text"/>	PCN#	<input type="text"/>
ID#	<input type="text"/>	Group#	<input type="text"/>	Phone	<input type="text"/>

Medicare Information

Medicare ID	<input type="text"/>
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Physician Information

Physician Name	<input type="text"/>	State	<input type="text"/>	Phone	<input type="text"/>
Fax	<input type="text"/>		Alt. Phone	<input type="text"/>	
Additional Comments	<input type="text"/>				

list all medications you are currently taking including Over The Counter, Herbal or Supplements.

Medications and Supplements	<input type="text"/>
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Drug or Food Allergies

Codeine (32)
 Sulfa (87)
 Penicillin (70)
 Tetracycline (93)
 Other(00)
 Unknown (00)

Other Allergies	<input type="text"/>
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Health Conditions

Diabetes (200)
 Hypertension (300)
 Heart Disease (400)
 Glaucoma (500)
 Stomach Disorders (600)
 Thyroid Disease (700)
 Arthritis (800)
 No Known Health Condition (000)
 Other(000)
 Unknown (00)

Other Health Conditions	<input type="text"/>
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