

Good Days ID: _____ Approval Date: _____ Patient is responsible for any remaining balance Good Days does not cover. <b>Note:</b> <i>An incomplete form will not be processed for reimbursement, and will be sent back to you for completion.</i>		<ol style="list-style-type: none"> <li>Complete and sign the form below</li> <li>Provide proof of payment which may include one of the following:             <ul style="list-style-type: none"> <li>Register Receipt (for cash payments)</li> <li>Bank or Credit Card Billing Statement</li> <li>Cancelled Check (both sides)</li> </ul> </li> <li>Provide a copy of invoice or EOB which indicates the following:             <ul style="list-style-type: none"> <li>Name of Provider</li> <li>Name of therapy/medication</li> <li>Amount paid by insurance</li> <li>Amount paid by patient</li> </ul> </li> <li>Please submit all documentation to:            Good Days Attn: Reimbursement            2611 Internet Blvd, Suite 105            Frisco, TX 75034</li> </ol>		
<b>Patient Information</b>				
Patient Name:	Date of Birth:			
Primary Phone:	Secondary Phone:			
Mailing Address:		City:	State:	Zip:
<b>Claim Information</b>				
Diagnosis:	Medication:	Strength/Dosage:	Quantity:	
Dispense Date:	RX Number:	Prescribing Physician:		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Address:		
Major Medical Insurance Name:		Drug Card Insurance Name:	Expected Reimbursement:	
I certify that the above information is true to the best of my knowledge. I understand that I am financially responsible for any balance beyond the approved amount. I also understand that Good Days' financial assistance is subject to my adherence to the Good Days guidelines and procedures.  _____ Patient/Guardian Signature  _____ Date		<b>FOR GOOD DAYS USE</b> Total Copay Paid by Patient: \$ _____ Patient Responsibility: \$ _____ Good Days Reimbursement: \$ _____ Remaining Patient Balance: \$ _____  _____ Good Days Signature                      Date		