



Orange Flag Building, 104 S Freya, Suite 114 • Spokane WA 99202 • (509) 532-8877 • Fax (509) 532-1375

Date: _____

Dear *Project Access* Patient Enrollment:

Please contact the following patient for possible enrollment in *Project Access*:

Name: _____

Address: _____
Street City State Zip

Work Phone: _____ Home Phone: _____

Please provide a brief description of medical reason for patient enrollment in Project Access. If possible, include ICD-9 diagnosis code(s):

Specialty patient needs to be referred to: _____

This patient may be eligible for *Project Access* because he/she is not insured through private health insurance, is not on Medicaid or Medicare, and is low income. I understand that insured patients are not eligible for *Project Access*, including the Medications Assistance Program, even if their insurance does not cover medications.

Patients will also be expected to sign a "Patient Responsibility" agreement prior to being enrolled.

I agree to see this patient at no charge as part of my volunteer commitment through *Project Access*.

Sincerely,

Physician Signature

Print or Type Physician's Name

Note: If you are providing specialty care for the patient, please provide the name of the patient's primary care physician/provider, if known.

Primary Care Physician/Provider of record: _____