Proof of Expenditure Form:
Travel and Premium

Phone: 866-316-7263
Fax: 866-316-7261

PAN grant recipients can submit PAN-approved expenses for travel or premium reimbursement using this Proof of Expenditure (POE) form.

Note: Providers and pharmacies cannot use this form to submit for payment. Please contact PAN for assistance if you would like payment to go to your provider or pharmacy. This form cannot be used to submit for medication or treatment reimbursement.

Instructions:

- ☐ **Complete, sign and date this POE form.** This form can be signed by either the patient or the individual completing the form on the patient's behalf.
- ☐ Attach **one** of the following types of expense documentation:
  - Proof of payment (receipts)
  - Credit card statement
  - Paystubs showing insurance premium cost or
  - Statement from your insurance company.
- ☐ Fax or mail the form and supporting documentation to:

Fax:	866-316-7261
Mailing Address:	PAN Foundation
	PO Box 221858
	Charlotte, NC 28222

For complete requests, payment will be issued in the form of a paper check within 10 business days of receipt.

Questions? Contact PAN at (866) 316-7263 Monday through Friday, 9 a.m. until 5 p.m. ET.

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Patient Information

First Name:_____ Last Name: _____

Date of Birth (MM/DD/YYYY):_____PAN ID Number:_____Group Number: _____

Expense Information

Are you requesting reimbursement for travel or premium assistance? (please check one)

◯ Travel assistance ◉ Premium assistance

For travel assistance, what is the type of your expense? (please check one)

◯ Transportation services ◯ Parking ◯ Fuel
◯ Meals ◉ Other (please specify): _____

Date of your expense (MM/DD/YYYY): _____

Requested reimbursement amount: _____

Person to whom PAN should send payment (please check one):

◉ Patient ◯ Caregiver/Parent/Guardian (Name:) _____

Street Address: _____

City:_____ State:_____ Zip: _____

Declaration

I attest and certify under penalty of law to the Patient Access Network Foundation that the information provided on this form is complete and accurate. I further understand that reported information may be verified by an audit as deemed necessary by the Foundation. I understand that assistance will terminate if the Foundation becomes aware of any fraudulent activity relating to the assistance provided by the Foundation. I understand that assistance may be limited to the terms and conditions established by the Foundation and that the Foundation reserves the right at any time, or for any reason, and without notice to (i) modify this form, (ii) modify or discontinue any or all the programs and the related eligibility criteria, or (iii) terminate assistance.

I authorize the Foundation and its employees, third party administrators, agents and other representatives to obtain information from my health care providers, insurance coverage information from my employer or insurance company(ies) as necessary to complete the reimbursement process or to verify the accuracy of any information provided with this form.

Signature **Date**

REMINDER: Did you attach your proof of payment or expense documentation?