



To: Aspen Area Pharmacies  
Dental Offices  
Physicians and Health Care Providers  
Health and Human Service Agencies

From: Aspen Valley Medical Foundation

Re: *Direct Assistance Funds - 2009*

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General Policies and Procedures:

- Medical Foundation must be notified by FAX before any funds are committed for patients, using attached request form. Feel free to make copies of form to keep on hand. Fax request form to AVMF before committing any funds for patient.
- AVMF strongly requests that participating health care providers reduce their fees whenever possible, as AVMF provides charitable dollars for these assistance funds.
- Patients are **NOT** to contact AVMF directly under any circumstances.
- When in doubt, contact AVMF by phone at 544-1298 or 544-7371.
- AVMF does not pay outstanding medical bills before this request.
- **Providers are to bill AVMF directly for reimbursement with the patient name and type of service: PO Box 1639, Aspen, CO 81612.**

Prescription Assistance:

- A maximum of \$150 per person per calendar year will be provided.
- Pre-approval from AVMF is required before script is filled.
- Provider notes AVMF Pharmacy Fund on prescription or to pharmacist.

Dental Assistance:

- A maximum of \$150 per person per calendar year is available for emergency care only.
- No other dental procedures will be considered other than basic emergency procedures to reduce pain or suffering of patient.
- Pre-approval from AVMF is required prior to any work being done.

Medical Assistance (vision and Mental Health):

- A maximum of \$250 per person per calendar year is available for **extraordinary** medical emergent needs.
- Pre-approval from AVMF is required.



## Request for Assistance

**FAX this form to AVMF 544-1562 for written pre-approval prior to committing funds!!!**

**Assistance from:**

       **Dental Fund**           **Prescription Fund**           **Vision Fund**           **Medical Fund**  
          (\$150 max)            (\$150 max)            (\$150 max)            (\$250 max)

**Amount requested \$** \_\_\_\_\_ **Date** \_\_\_\_\_

**Reason for Request** \_\_\_\_\_  
\_\_\_\_\_

**Explain Financial Need** \_\_\_\_\_  
\_\_\_\_\_

**Name of patient** \_\_\_\_\_ **Age** \_\_\_\_\_

**Has patient received help from AVMF this calendar year?**            **Yes**    **No**

**Your name** \_\_\_\_\_

**Agency name** \_\_\_\_\_

**Best contact phone number** \_\_\_\_\_ **FAX** \_\_\_\_\_

**For AVMF Use Only**

**Approval**             **Denial**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Comments:**