BPIC Referral Request for Funding

Mission: To provide a financial health care safety net for those in our community who are uninsured or under-insured

What services do BPIC fund?

With an approved referral from a provider, BPIC can provide financial aid for:

- **Diagnostic/Radiology Studies**

30/30/40 plan whereby BPIC and BGH pay 30% of the study with the patient being responsible for 40%. BGH does have a sliding scale through their BGH Cares program for further patient assistance.

- **Medical Supplies**
- **Prescription Medications**
- **Specialist Referrals**

BPIC will cover the initial $100 to a specialist provider for consultation requested by provider

- **Lab work**

Basic lab work will be covered through a partnership between BPIC and BGH.

- **BP Cuff / SAD light**

BP cuffs and SAD lights can be picked up at White Cross Pharmacy with presented form.

Date: _____

Ordering Provider: _____

Provider Office: _____

Provider FAX #: _____

PLEASE ATTACH PATIENT DEMOGRAPHIC SHEET AND COMPLETE THIS FORM AND FAX to 208-265-2229.

**** Please do not include any patient identifiers on this form ****

SELECT PATIENT FINANCIAL NEED: ☐ *uninsured*
☐ *under-insured with high deductible*
Please select from following: ☐ *patient voices financial need*

☐ **RADIOLOGY STUDIES:** _____

30/30/40 rule applies unless otherwise requested with extraordinary circumstances explained below.

☐ **MEDICATION ASSISTANCE AMOUNT $:** _____

Which medications? _____

Patient Pharmacy: _____

Please request a financial amount for one month or specified time frame that will be paid directly to patient's local pharmacy.

☐ **SPECIALIST CONSULT REQUEST:** _____

☐ **OTHER REQUEST:** _____

- *Mammograms/STD Testing- Please refer to Panhandle Health District*
- *Needs Primary Care Provider- Please recommend Kaniksu Community Health*

PROVIDER WILL RECEIVE REQUEST APPROVAL IN WRITING WITHIN 7 DAYS

☐ **LAB WORK REQUEST:** ***please circle***

CBC	BMP	Lipids	A1C	TSH
LFTs	CMP	UA	Urine Culture	

Other: _____

_____

_____

PROVIDER WILL RECEIVE LAB WORK REQUEST APPROVAL IN WRITING WITHIN 2 DAYS

☐ **BP Cuff / SAD light:**

If your patient is in need, please give this form to White Cross Pharmacy for a free blood pressure cuff or SAD light covered by BPIC.

BRIEF DESCRIPTION OF PATIENT NEED: _____

_____

_____

_____

Please write a brief sentence on patient's behalf explaining their health situation and need. Do not include patient name, date of birth or any patient identifiers.

☐ **Please check if your request falls within generally accepted medical practice and evidence based guidelines.**

* **Patient testimonials are welcomed and gladly accepted!** **Email: chryl@bpicc.org**

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