MEDICAL EXPENSE ASSISTANCE

Request Form

Applicant Information

Name (Last)		(First)	(Middle Initial)
Address		City	
State	Zip code	Email Address	
D.O.B.		Mobile Phone	Home Phone

May CDBF provide you with updates and mailings? ☐ YES ☐ NO

Are you an adult applying on behalf of a minor? ☐ YES ☐ NO

Complete the section below if the applicant is a minor

Guardian's Name (Last)	(First)	(Middle Initial)
Relationship to Applicant	Email Address	Primary Phone

Do you authorize CDBF to publicize your child's photo? ☐ YES ☐ NO

Parent/Guardian Signature ______________________________

Media Release (Optional)
I give permission to the Cody Dieruf Benefit Foundation [CDBF] to publicize my photographs, application responses, and other forms of communications for marketing and outreach purposes. I understand these purposes may include physical publications in print advertising, appeal letters, flyers, and/or brochures as well as digitally on our website and social media accounts.

Applicant/Guardian Signature ______________________________

If you do ***not*** want to share your photographs and statements with CDBF for marketing and outreach purposes, do not sign the above release. We may still request photos and statements from you, but this content will not be publicized without express consent.

Out-Of-Pocket Expense Information
What is the reason you've accrued an out-of-pocket medical cost(s)?

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Are these costs related to medical care, health maintenance, etc., which provide some health benefit to the patient? ☐ YES ☐ NO

Has the patient's provider prescribed, recommended, and/or suggested the expenditure listed above? ☐ YES ☐ NO

Please include your provider's information below.

Provider Name	Clinic Name	Phone Number

Number of individuals who traveled (including the patient) ______________________

Briefly describe your expenses, as well as the cost per expense.

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Have you already paid for these expenses? ☐ YES ☐ NO

Total Expense	Amount Paid	Amount Unpaid

Please attach receipts, estimates and/or other documentation for these expenses.

Please attach insurance documentation showing your annual deductible and proof that you have had to pay and/or must pay this entire amount in the current calendar year.

Submit to the Cody Dieruf Benefit Foundation via email at pam@breathinisbelievin.org or via mail to PO BOX 7361, BOZEMAN, MT 59771.