Benefits without Barriers Program Application

Name:_____

Mailing Address:_____

Phone:__(_____)_____

Email Address:_____

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What type of medical equipment are you seeking?

Which insurance type(s) do you have? (Check all that apply)

- **Original Medicare (parts A & B)**
- **Medicare Advantage (parts A, B and D)**
- **Medicaid (OHP)**
- **Medigap (Medicare supplemental plan)**

Who is your insurance provider(s)? Be specific.

Did you appeal the insurance company's decision? (Circle one) **Yes** **No** **In progress**

List 3 donation sites you contacted.

1) **Name:**_____
   Address:_____
   _____
2) **Name:**_____
   Address:_____
   _____
3) **Name:**_____
   Address:_____
   _____