Application for coverage of Lake Express Fare

Patient Information:	**Contact Information:**
Name:____________________________________	Home Phone:____________________
Address:____________________________________	Work Phone:____________________
City/State/Zip:____________________________________	Cell Phone:____________________
DOB:____________________________________	Email:____________________
Age:____________________________________	Fax:____________________
If this form is being filled out by someone other than the patient:	**Contact Information:**
Name:____________________________________	Home Phone:____________________
Relationship to Patient:____________________________	Work Phone:____________________
Address:____________________________________	Cell Phone:____________________
City/State/Zip:____________________________________	Email:____________________
DOB:____________________________________	Fax:____________________
Age:____________________________________	

Primary Physician Info:
Name:____
Office phone:____________________________________ Office Fax:____________________

Please describe the patient's medical condition:

Patient Signature:	**Date:**
Parent/Guardian Signature (if under 18)**:**	**Date:**
Preparer Signature(if form not filled out by patient):	**Date:**

Waves of Hope
www.WavesofHopeMI.com

1918 Lakeshore Drive
Muskegon, MI 49441
WavesofHopeMI@gmail.com

Fax:231.755.2427
Phone: 866.914.1010