Request for Patient Assistance Program Enrollment

[Your Name]

[Your Address] [City, State, Zip Code]

[Your Email Address] [Your Phone Number]

[Date]

Patient Assistance Program Coordinator

[Pharmaceutical Company Name] [Company Address] [City, State, Zip Code]

Dear Program Coordinator,

I hope this letter finds you well. I am writing to formally request enrollment in the Patient Assistance Program for [Name of Medication] due to my current financial situation and inability to afford my prescribed medication.

I have been diagnosed with [Diagnosis] and my healthcare provider, Dr. [Doctor's Name], has prescribed [Name of Medication] for my treatment. Unfortunately, my current financial constraints prevent me from being able to acquire this medication.

Attached to this letter, you will find the necessary documentation, including my medical records and proof of income, to support my application for the Patient Assistance Program. I believe that participation in this program would greatly enhance my quality of life and improve my health outcomes.

I kindly request your assistance in processing my application and look forward to your prompt response. Thank you for considering my request. Should you need any more information, please feel free to contact me at the provided phone number or email address.

Sincerely,

[Your Name]