

**CANCER WIG FOUNDATION, INC.  
WIG REIMBURSEMENT FOR CANCER PATIENTS**

**REIMBURSEMENT POLICY**

Funds raised for the Cancer Wig Foundation, Inc. will be used to reimburse Minnesota resident cancer patients for a wig or prosthetic needed for medical hair loss caused by cancer treatment. The Cancer Wig Foundation, Inc. is not part of the Look Good Feel Better program nor is it associated with the American Cancer Society. The Cancer Wig Foundation, Inc. is funded strictly by donations from individuals, civic groups, corporations and fund raisers. This fund is a 501(c)3 organization and all donations are tax deductible.

1. Referral must come from a cosmetologist, esthetician or nail technician who is a member of the Minnesota Salon & Spa Professional Association (MNSSPA). The cosmetologist portion of the request form must be completed by the MNSSPA member with an original signature. Copies, facsimile, or signatures other than that of an MNSSPA member will not be accepted. MNSSPA/NCA membership number must be included.

2. Reimbursement up to \$50.00 will be allowed for only one wig purchased by any one cancer patient per life time. Reimbursements will be made in order received as funds are available.

3. A receipt and Dr.'s prescription (Dr. is not required to sign the CWF request form) MUST be presented with the appropriate form completed by the cancer patient and MNSSPA member. Cancer patient must sign form. MNSSPA member may not sign for the cancer patient.

4. Wig may be purchased from any source.

5. Cancer Patient must currently be receiving radiation or chemotherapy treatment.

6. Cancer patient must be a resident of the State of Minnesota.

7. Requests must be submitted within 60 (sixty) days of the wig purchase date to receive reimbursement.

8. Reimbursement requests MUST meet the criteria in order to be eligible for reimbursement. Forms that are not filled out completely will be returned to the member cosmetologist and/or cancer patient.

9. Reimbursements will be paid to the cancer patient only. Requests for payment to the cosmetologist will not be honored.

10. Requests must be from a cancer patient who has suffered hair loss. Requests from individuals who have suffered hair loss due to a medical condition other than cancer will not be honored.

11. Requests for reimbursements must be sent to:

Cancer Wig Foundation, Inc.  
c/o MNSSPA  
6950 France Avenue, S. Suite 18  
Edina, MN 55435  
Telephone: 952/925-9731

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**Cancer Patient Reimbursement Request Form**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

(Patient must be a resident of Minnesota)

Telephone:(\_\_\_\_)\_\_\_\_\_ Email \_\_\_\_\_

Cancer Diagnosis: \_\_\_\_\_

(required)

Patient's Signature: \_\_\_\_\_

Cost of wig purchased: \_\_\_\_\_

Where purchased: Store/Salon: \_\_\_\_\_

Address: \_\_\_\_\_

Attending Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Optional information: Was this wig for a \_\_\_\_\_ man, \_\_\_\_\_ Woman, \_\_\_\_\_ Child  
Approximate age \_\_\_\_\_

Referred by Minnesota Salon & Spa Professional Association Member ONLY:

MNSSPA/NCA Member # 170 \_\_\_\_\_ - \_\_\_\_\_ exp date \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_ Telephone:(\_\_\_\_)\_\_\_\_\_

MNSSPA Member Signature: \_\_\_\_\_

This form must be completed and submitted by a member of MNSSPA and must include sales receipt and Dr.'s Prescription for reimbursement.

Mail to: Cancer Wig Foundation Inc.  
c/o MNSSPA  
6950 France Avenue, S. #18  
Edina, MN 55435