INTEGRATED DX

Dear Patient,

Thank you for your interest in our Financial Hardship plan. So that we can determine your eligibility, please complete the attached application form, and return it to the address listed on your invoice, along with one or more of the required documents listed below:

- A copy of last year's W2 form
- A copy of last year's income tax return
- A copy of your most recent pay stub(s)
- Proof indicating you are eligible for local, state, or federal assistance programs

Once we receive your completed application and documentation, we will determine if you meet the established criteria. Please allow approximately two weeks for your application to be processed. Do not make any payments until you receive notification regarding the status of your request. *Applying for acceptance to our Financial Hardship Plan does not guarantee reduced charges.*

If you have any additional questions or concerns, please contact our billing department.

Sincerely,

Billing Customer Service

INTEGRATED DX

Patient Financial Assistance Form

**Patient Name:**_____ **Telephone Number:**_____
**Address:**_____ **Patient D/O/B:**_____
**City:**_____**State:**_____
**Invoice Number(s):**_____

**Please complete all information accurately. The signature of the patient or patient's guardian is required.**

**Please make sure to attach the required supporting documentation(s).**

1. Does the patient have sufficient resources to pay for the testing and/or the deductible and coinsurance?

☐ Yes If the answer is "Yes", you are financially responsible for payment
☐ No If the answer is "No", continue on with form

2. Is any source other than the patient legally responsible for the patient's medical bills (i.e. Medicaid, local welcare agency, guardian, or other insurance program?

☐ Yes ☐ No If answer is "yes" please list:
**Insurance Company Name:**_____
**Address:**_____
**Member I.D.:**_____
**Other Source:**_____

3. Patient/legal guardian's monthly household resources

| | |
|---|---|
| Salary | $_____ |
| Social Security | $_____ |
| Cash/Welfare Payment | $_____ |
| Family Contribution | $_____ |
| Income from Savings Accounts, CD's, etc. | $_____ |
| **TOTAL** | **$_____** |

4. Number of family members in household_____

**I hereby acknowledge that the above information is true and correct according to the best of my knowledge. I also authorize the release of any and all financial records necessary to verify the above information. I understand that if I do not qualify, I will be notified I am responsible for the full amount due. I hereby acknowledge that I am neither related to nor employed by the physician who ordered the testing.**

Patient Name (Print):_____
Guardian Name (if applicable)(Print):_____
Responsible Party Signature:_____
Date:_____

| Bill Number | Amount $ | Approved | Denied |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| Date Received: | | | |
| Billing Representative: | | | |