

## Dear Patient,

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

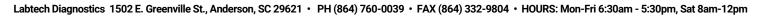
- · A copy of last year's W2 form
- A copy of last year's income tax return
- A copy of your most recent pay stub (s)
- A proof source indicating that you are eligible for local, state, or federal assistance programs.

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 into our Financial Assistance Program does not guarantee reduced charges.

If you have any additional questions or concerns, please do not hesitate to contact us. Thank you for using Labtech Diagnostics. We look forward to serving you in the future.

Sincerely,

Patient Billing Customer Service





## Patient Financial Assistance Form

Patient Name:		Telephone Number:		
Address:		Patient Date of Birth:		
City:		State:	Zip Code:	<u> </u>
Invoice Number(s):			Lab Code:	
Please complete all informa	tion accurately. The si	gnature of the patient or	patient's guardian is required.	
Yes If answer is "	sufficient resources to	p pay for the testing and ally responsible for payr	l/or the deductible and coinsura	ince?
Yes No If Insurance Company Address: Member I.D.:	velfare agency, guard answer is "Yes" list: Name:	ian or other insurance p		
3. Patient/legal guardian's Salary Social Security Cash/Welfare Payme Family Contribution Income from Savings Other	ent s Accounts, CDs, etc.	\$\$ \$\$ \$\$ \$\$		
4. Number of family members in household:				
knowledge. I also authori information. I understand	ize the release of an I that if I do not qual I I am neither related	y and all financial rece ify, I will be notified a	ct according to the best of my ords necessary to verify the a nd Labtech Diagnostics will k he physician who ordered the	above oill me. I
For Official Use Only:		T	1	
Bill Number	Amount \$	Approved	Denied	
Date Received:				
PCS Rep:	l			
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Labtech Diagnostics 1502 E. Greenville St., Anderson, SC 29621 • PH (864) 760-0039 • FAX (864) 332-9804 • HOURS: Mon-Fri 6:30am - 5:30pm, Sat 8am-12pm

