PRISM HEALTH

FEE WAIVER REQUEST FORM

Prism Health has agreed with health benefit plans to make a good faith effort to collect charges, co-payments, coinsurance, and deductible amounts owed by patients. Recognizing that circumstances may arise when an individual is unable to pay in full at the time of service, Prism Health offers patient's experiencing hardships the opportunity to apply for: a waiver of discount of fees, delayed payment plans, or forgiveness of debt based on individual circumstances. Prism Health screens each request taking into consideration income, household size, benefits, and the circumstances for the request. Prism Health does not guarantee that a request will be granted.

To consider your request, Prism Health must ask for certain personal and financial information. All information will be held confidential according to our privacy policy. If needed to render a decision, Prism Health may request additional documentation regarding your request such as income tax returns, recent paystubs, or proof of governmental assistance. A decision will be communicated to you within ten (10) business days through MyChart. If you do not have a MyChart account, you will be contacted by phone and the number you provide below.

DIRECTIONS: Please complete this form to the best of your ability and sign your completed form. Return your form to Prism Health in person, by mail, by fax or by email (see below for contact information).

YOUR INFORMATION			
Name:		Date of Birth:	
Email:		Phone Number:	

YOUR FINANCIAL INFORMATION	
Annual Income:	$
Number of Dependents in Your Household:	
Name of Other Financially Responsible Person in Household:	
Number of Employed Adults in Your Household:	
Number of Unemployed Adults in Your Household:	
Number of Retired Adults in Your Household:	
Place an 'X' in the boxes below next to any of the benefits you are currently receiving.	

	State financial assistance		WIC		SNAP Benefits		Medicaid

ASSISTANCE REQUESTED			
Place an 'X' in the boxes below next to the type of assistance you are requesting.			
	One Time Support (for a specific date of service)		Ongoing Support (for up to 3-months)

Continue on other side →

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REASON FOR REQUEST
In the box below, please explain the reason for your request. Attach additional sheets if needed.

My signature below indicates that the information I provided is true and accurate to the best of my knowledge. I will provide Prism Health updated information should it change.

____ ________________________

Patient Signature **Today's Date**

FOR OFFICE USE ONLY							
Date Form Received:		Received by:		Patient MRN:			
Reviewed By: *(name and title)*							
Request Approved or Denied:		Request Approved		Request Denied			
Denial Reason:							
Approved For:		Reduced Deductible		Debt Forgiveness			
		Reduced Copayment/Coinsurance		Discounted Cash Services			
Duration of Approval:		One Time Support		Ongoing Support End Date ___/ ___/ ___			
Additional Comments:							
Date Patient Notified:		Notified by:		Email		Phone		MyChart