Patient Financial Hardship Application

Patient Name: _____ **SSN:** _____

Address: _____

STREET APT# CITY STATE ZIP CODE

Telephone Number: (_____)_____ **Patient Date of Birth:** _____/_____/_____

1. Does this patient have health insurance coverage? Check one: ☐ Yes ☐ No

If "Yes," please list responsible party information: (Please include a copy of insurance card.)

Insurance Carrier Name, Address, Phone Number and Policyholder Name and ID#:

_____

_____

2.

FINANCIAL INFORMATION(ALL VALUES SHOULD BE YEARLY AMOUNTS FOR ENTIRE HOUSEHOLD)

Total Gross Yearly Income $_____
(Include pay stub, W-2, unemployment or disability statement, or other verification of income)

Household Size:_____
(Number of people who contribute to or are dependent on your household income)

Your application may be subject to audit or request for additional documentation.

I hereby swear under penalty of state and federal law that the above information has been provided as accurately as possible. I authorize National Labs to verify this information for the sole purpose of assessing financial need. I understand that if I do not qualify for financial hardship, I will be notified directly by National Labs and be held to my outstanding balance. If my current financial condition changes or improves, I agree to notify National Labs.

Patient Name (Print): _____ **Date:** _____

Patient Signature:_____ **Date:** _____

Responsible Party Signature: _____ **Date:** _____

Submit this signed Agreement to:
National Labs
Attn: Financial Support Department
3948 Trust Way, Building B
Hayward, CA 94545

For Internal Use Only:

Process Date	Total Owed	# of Accounts	% Approved	Begining Date	Expiration Date
Processor Last Name				Denial Reason	
Approver Name			Approver Signature		