PRISM
HOME MEDICAL SUPPLY SPECIALISTS
A HENRY SCHEIN® COMPANY

FINANCIAL ASSISTANCE APPLICATION

Please mail to:
Prism Medical Products
Attn: Billing Department
PO Box 476, Elkin, NC 28621
billinginfo@prism-medical.com or fax to: 800-975-6321

Prism Medical Products, LLC ("PRISM") understands you may have difficulty paying your remaining balance. Therefore, we offer an Assistance Program to help meet your needs. Please take time to fully complete the application form and promptly submit to our office for review.

PATIENT AND APPLICANT INFORMATION

Full Name

Patient ID

Address

Billing Address, if different

Phone Number

Alt Number

E-Mail

HOUSEHOLD MEMBERS: Age 0-21 | Age 22-64 | Age 65+ | TOTAL

HOUSEHOLD INCOME: PLEASE COMPLETE ALL SECTIONS

Remember: You Must include proof of income with your application.

Total Monthly Household income? $

Balance of ALL checking accounts? $

Balance of ALL savings accounts? $

TOTAL INCOME $

If you have no proof of income or no income, please attach an additional page with an explanation

Have you applied or are you receiving any other services?

Medicaid	Yes	No
Foodstamps	Yes	No
Financial	Yes	No
Assistance/Charity Program	Yes	No

MONTHLY EXPENSES: PLEASE COMPLETE ALL SECTIONS

Rent/Mortgage	$	Credit Cards	$
Utility/Phone/Electricity	$	Medical Bills	$
Food Expense	$	Personal/Clothing	$
Insurance Premiums	$	Child Care	$
Auto Loan(s)	$	Other	$
Personal Loan(s)	$		

**Please use NA for expenses that are not applicable.

TOTAL EXPENSES $

PLEASE DESCRIBE YOUR CURRENT FINANCIAL SITUATION

****This Section is Required**

**Please make sure to complete all sections above and use NA for any items that do not apply to your situation. Please attach copies of all proof of income such as pay stubs, disability statement, unemployment compensation statement, and tax records. If any section of this application is incomplete, this form will be returned to you and may delay delivery of your supplies. PRISM reserves the right to request additional documentation.

I affirm that the information provided with this application is true and accurate. I agree that if there is any change in my financial circumstances, that I will notify PRISM. I understand the information provided herein will be used to determine my eligibility for hardship assistance from PRISM and shall not be sold, distributed, or used in any other way or for any other purposes.

Patient Signature

Date

NOTE: **If approved, your application will be valid for 1 year from date of approval.

FINANCIAL ASSISTANCE PROGRAM

Dear Prism Medical Products, LLC ("PRISM") Client,

PRISM has a responsibility to send invoices to our clients in an attempt to collect patient responsibility portions of all claims. We are proud to offer a program that enables our patients to receive assistance with any remaining balance once claims have been paid or if no insurance is active. If there is any additional information that you can provide us regarding a secondary or tertiary policy that would reduce this responsibility, please do not hesitate to contact our office. We will put forth our greatest efforts to reconcile any balance with this information.

If you find yourself with a remaining balance that is creating a hardship for you or your loved one, you may ask to apply for our Financial Assistance Program. We make this program available because we understand the cost of supplies and your ongoing health care expenses may prevent you from acquiring the level of care needed to assist you during your healing process whether it is short-term or long-term.

You will need to complete the enclosed application in its entirety. Please do not leave any open fields. Please provide us with accurate information. You have an additional opportunity to further explain any hardship or circumstances located at the bottom of the application form. If you need additional space, please feel free to use a separate sheet of paper. Please attach supporting documentation required for proof of income. We accept the following documents:

1. Current pay stub
2. Disability statement
3. Unemployment compensation statement
4. Tax records

Once completed, you may submit it to our office via billinginfo@prism-medical.com fax (800) 975-6321 or mail to: PO Box 476, Elkin, NC 28621. Please make it attention to the Billing Department.

We will review your case and respond to you in a timely manner. You will receive by mail, notification of approval/denial status. If your application is approved, it will be effective immediately for the term of one year and will be applied to any outstanding balance. If your application is denied, you may resubmit an application at any time with updated supporting documentation.

If you have any additional questions you may contact the Billing Department by calling (888) 244-6421. We will be happy to assist you further.

Prism Medical Products, LLC