



FINANCIAL HARDSHIP PROGRAM

Dear Prism Customer;

When there is a remaining balance for services provided, we are required by law to send an invoice. If there is any additional information that you may provide us such as a secondary or tertiary policy that will help us reduce this amount, please don't hesitate to contact our office. We will make the adjustment.

If the remaining balance is creating a hardship for you or your loved one, you may ask to apply for our Financial Hardship Program. We understand the delicate balance of finances within a household without adding an ailment to the equation. We are also citizens of this great nation coping with a difficult economy. Difficult times ranging from loss of employment, a sickness, disability or advanced age can often interfere with either you or your loved one receiving quality healthcare. We appreciate your initiative to be personally involved in your healthcare decisions.

So we may continue to provide the highest level of customer service while remaining in compliance with the requirements set forth by both insurance and Medicare/Medicaid, we have made available a financial hardship program to patients that may otherwise go without the necessary supplies required for their particular situation whether it would be long-term or short-term. We will process your request in a timely manner and treat your information with the highest level of confidentiality.

The process is simple. Please take the time to complete the following application and provide us with as much information you can, as quickly as possible. There are opportunities to explain your circumstances in your own words. You have our guarantee we will review your case and respond to you in a timely manner. Once completed, you may submit it to our office via fax at 800-975-6321 or if you prefer you may mail to PO Box 476, Elkin, NC 28621, make it attention Billing Department.

If you have any further questions, you may contact our billing department at 800-975-6321, extension 726. We will be happy to assist you further through the process.

You have our best wishes for quality healthcare!

Prism Medical Products, LLC



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APPLICATION FORM

Patient Name (print) _____ Acct # _____

Street _____ Apt _____ City _____ State _____ Zip _____

Billing Address, if different _____

Email _____ Phone _____ - _____ - _____ Alt Phone _____ - _____ - _____

Prism Medical Products, LLC understands you may have difficulty paying your remaining balance. Therefore, we are pleased to offer a Hardship Program to help meet your needs. Please take time to fully complete the application form and promptly submit to our office for review. It is important to us that you have access to the equipment you need.

HOUSEHOLD

Household Members: Age 0-21 _____ Age 22-64 _____ Age 65+ _____ TOTAL _____

INCOME

Total Monthly household income? \$ _____ Have you applied or receiving any other services, e.g. Balance of ALL checking accounts? \$ _____ Medicaid, Food stamps? If yes, please list _____ Balance of ALL savings accounts? \$ _____ TOTAL \$ _____

EXPENSES

Rent/Mortgage \$ _____ Please explain any other expenses. Utility/Phone/Heat \$ _____ Food \$ _____ Personal/Clothing \$ _____ Child Care \$ _____ TOTAL \$ _____

IN YOUR OWN WORDS PLEASE DESCRIBE YOUR CURRENT FINANCIAL SITUATION

I believe that I am a low income user of home medical equipment which was supplied by Prism Medical Products, LLC. I understand that I am responsible for the co-insurance, non-deductible portion of my Medicare and/or private insurance coverage. I represent to Prism Medical Products, LLC that if I were required to pay my co-insurance portion of the monthly equipment rental/purchase, I would have to deny myself the needed medical equipment services. 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 _____