PRISM
HOME MEDICAL SUPPLY SPECIALISTS

Financial Assistance Program

Dear Prism Client;

We are required by law 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 clients to receive assistance with any remaining balance considered to be patient responsibility once claims have been paid. If there is any additional information that you may provide us regarding a secondary or tertiary policy that may 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 this is not an option for you and 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 to our clients because we understand the cost of supplies and your 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.

Prism strives to make this process simple and fast. You will need to complete the application in its entirety. Please do not leave any open fields and provide us with as much household information as available. You have an additional opportunity to further explain any hardship or circumstances in your own words located at the bottom of the application form. 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 mail to: PO Box 476, Elkin, NC 28621. Please make it attention to the Billing Department.

If you have any additional questions you may contact our billing department directly by calling (888)244- 6421. They will be happy to assist you further.

You have our best wishes for the highest level of client care and quality health care!

Prism Medical Products, LLC

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FINANCIAL ASSISTANCE APPLICATION
Please mail to: PO Box 476, Elkin, NC 28621
or fax to: 800-975-6321

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 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. 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?
Balance of ALL checking accounts?	$_____	Medicaid _____Yes _____ No
Balance of ALL savings accounts?	$_____	Foodstamps _____ Yes _____ No
TOTAL	$ _____	Charitable organization _____ Yes _____ No

EXPENSES

Rent/Mortgage	$_____	Please explain any other expenses or type of assistance.
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 _____