Provider Hardship Form

Dearest Patient,

Because your claims for the services rendered has been processed and a significant amount has been placed under patient responsibility, in order to follow proper insurance billing guidelines, to offer any level of discounts to any balance we are obligated to collect, we are required to have in writing that amount required causes a financial hardship. By completing and submitting the form below you are stating that the additional patient responsibility deemed by your insurance plan after the processing of your claim(s) is outside of your financial means and is non-collectible as it will create a financial hardship.

Patient Name ___________________________ Date of Birth __________________________

Amount Already Paid ______________ Amount Due for payment ___________________

___ I can afford a discounted payment plan of $ __________ per month due on the 28th of each month

___ I can afford a onetime settlement amount of $ ____________ which is 40% off my balance due

___ NO, I cannot afford any payment arrangement of any kind

Patient Signature ______________________ Date of Signature ______________________

To be completed by Your Provider Name staff:

Approved by ____________________________ Approved Date _______________________