FINANCIAL ASSISTANCE APPLICATION

bostonheart diagnostics®

STEP 1: PATIENT INFORMATION

Name (last, first, middle):	Date of Birth (mm/dd/yyyy):	Gender (M/F):
Email Address:	Home Phone Number:	Cell Phone Number:
Address:	City:	State & Zip Code:
Do you have active health insurance? (Y/N)	Household Size:	Household Income (pre-tax):
Boston Heart Accession Number (if known):	Ordering Physician:	Client ID:

STEP 2: SELECT ASSISTANCE TYPE—PICK ONE OPTION

○ **Option 1: Patient does not carry insurance**

○ **Option 2: Patient does carry insurance***

Out-of-pocket costs are discounted on a sliding scale based on household size and pre-tax income **is under the amount** listed in the table below.

Household Size	100% Discount	90% Discount	80% Discount	70% Discount	60% Discount
1	$24,980	$31,225	$37,470	$43,715	$49,960
2	$33,820	$42,275	$50,730	$59,185	$67,640
3	$42,660	$53,325	$63,990	$74,655	$85,320
4	$51,500	$64,375	$77,250	$90,125	$103,000
5	$60,340	$75,425	$90,510	$105,595	$120,680
6	$69,180	$86,475	$103,770	$121,065	$138,360
7	$78,020	$97,525	$117,030	$136,535	$156,040
8	$86,860	$108,575	$130,290	$152,005	$173,720

Income values are pre-tax and based on 2019 poverty guidelines (https://aspe.hhs.gov/poverty-guidelines). Boston Heart uses two times the federal poverty guidelines. Some insurance carriers choose to use the federal poverty guidelines. This may disqualify some applicants for assistance.

Extenuating circumstances considered – check if applicable and provide supporting documentation: ○ Unemployed ○ Deceased Spouse

*Please complete the insurance information section below and include a copy of the patient's insurance card, front and back, along with this application. Patients covered by contracted insurance carriers may not be eligible for financial assistance.

Insurance Carrier: ______________________ Insured: ______________________

Policy/Member ID: ______________________ Group: ______________

STEP 3: PATIENT ATTESTATION

I hereby acknowledge that the above information is true. I understand that I am responsible for supplying Boston Heart with the required proof of income to verify the information provided on this form for the purposes of assessing financial need. I understand that if I do not qualify, I will be notified and Boston Heart will bill me for the services rendered.

→ **Patient Signature:**	**Date:**

STEP 4: PATIENT MUST PROVIDE INCOME DOCUMENTATION

Boston Heart must receive confirmation of patient's household income before providing patient assistance, including: wages, social security, pension/retirement, dividends/interest, rents/royalties, unemployment or worker's compensation, alimony, or other assets. **Please provide the patient's most recent form 1040 (from the patient's federal tax return) or Social Security (SSI) benefits.**

Fax completed application and all supporting documents to Boston Heart Billing Customer Care at 866.324.3929.

For Internal Use Only

Reviewed by:	Amount Due:	% Approved:	Adjusted Amount:	Denial Reason:

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