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 <u>does not</u> carry insurance**	○ **Option2: Patient <u>does</u> 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	40% Discount
1	$14,580	$21,870	$29,160	$36,450	$43,740	$58,320
2	$19,720	$29,580	$39,440	$49,300	$59,160	$78,880
3	$24,860	$37,290	$49,720	$62,150	$74,580	$99,440
4	$30,000	$45,000	$60,000	$75,000	$90,000	$120,000
5	$35,140	$52,710	$70,280	$87,850	$105,420	$140,560
6	$40,280	$60,420	$80,560	$100,700	$120,840	$161,120
7	$45,420	$68,130	$90,840	$113,550	$136,260	$181,680
8	$50,560	$75,840	$101,120	$126,400	$151,680	$202,240

Income values are pre-tax and based on 2023 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 or forward via email to Pass@Bostonheartdx.com.

For Internal Use Only

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