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	$15,060.00	$22,590.00	$30,120.00	$37,650.00	$45,180.00	$60,240.00
2	$20,440.00	$30,660.00	$40,880.00	$51,100.00	$61,320.00	$81,760.00
3	$25,820.00	$38,730.00	$51,640.00	$64,550.00	$77,460.00	$103,280.00
4	$31,200.00	$46,800.00	$62,400.00	$78,000.00	$93,600.00	$124,800.00
5	$36,580.00	$54,870.00	$73,160.00	$91,450.00	$109,740.00	$146,320.00
6	$41,960.00	$62,940.00	$83,920.00	$104,900.00	$125,880.00	$167,840.00
7	$47,340.00	$71,010.00	$94,680.00	$118,350.00	$142,020.00	$189,360.00
8	$52,720.00	$79,080.00	$105,440.00	$131,800.00	$158,160.00	$210,880.00

Income values are pre-tax and based on 2024 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@Bostoheartdx.com

For Internal Use Only

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