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	$15,650	$23,475	$31,300	$39,125	$46,950	$54,775
2	$21,150	$31,725	$42,300	$52,875	$63,450	$74,025
3	$26,650	$39,975	$53,300	$66,625	$79,950	$93,275
4	$32,150	$48,225	$64,300	$80,375	$96,450	$112,525
5	$37,650	$56,475	$75,300	$94,125	$112,950	$131,775
6	$43,150	$64,725	$86,300	$107,875	$129,450	$151,025
7	$48,650	$72,975	$97,300	$121,625	$145,950	$170,275
8	$54,150	$81,225	$108,300	$135,375	$162,450	$189,525

Income values are pre-tax and based on 2025 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. For families/households with more than 8 persons, add $5,500 for each additional person.

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@bostonheart.eurofinsus.com

<u>For Internal Use Only</u>

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