Physicians Ancillary Services, LLC.
1080 Elm Street, Suite 102 | Rocky Hill, CT 06067
Phone: 877-819-5462 | Fax: 888-896-8735

PATIENT FINANCIAL HARDSHIP POLICY

Physicians Ancillary Services, LLC. is committed to providing clinical laboratory services to all patients regardless of their ability to pay. Patients who are unable to pay for their clinical laboratory testing and who are uninsured and meet the criteria identified in our Patient Financial Hardship Policy may be eligible to receive an adjustment for some or all of their laboratory charges.

ELIGIBILITY CRITERIA

This program is available to patients who cannot afford to pay their bill. Patients will be required to submit the following information to verify their eligibility for this program:

1. W-2 form to verify your income.
2. Documentation of eligibility for federal food stamps, State Medical Assistance, or the Hill-Burton Program. If you are eligible for any of these programs, you will automatically qualify under our program.
3. If you do not currently qualify for these programs, we will take into account your income and family-unit size based on guidelines provided to us by the US Department of Health and Human Services.
4. Because of certain federal and state regulations, we cannot waive co-payments or deductibles from insurance companies. Therefore, our Patient Financial Hardship Program is only available to patients who do not have health insurance coverage.

HOW TO APPLY

If you cannot afford to pay your bill and you are uninsured, please complete the enclosed application and return it with a copy of your bill.

Please return the application within thirty (30) days of receipt, so that we can place your bill on hold while we make our determination.

Based on your request and evidence of your financial income, we will work with you to determine whether you qualify for our program. We will then notify you of whether you qualify for financial assistance from Physicians Ancillary Services, LLC. and indicate what portion of the invoice has been credited. If you do not qualify, we will be happy to develop a convenient payment schedule for you.

PLEASE FAX OR EMAIL THE FOLLOWING APPLICATION to:
888-896-8735 OR dknorr@physiciansancillary.com

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PATIENT FINANCIAL HARDSHIP FORM

Patient Name: ____

Address: ____

City: ______________________________ State: ___________ Zip Code: ____________

Home Phone: ___________________________ Cell Phone: ___________________________

Employer: ____

Annual Income: _______________________ Supplemental Income: ______________________

Number of dependent family members residing in your household: _____________________

Have you applied for, or are you currently enrolled in, any kind of State, Federal or Community assistance programs? If so, list below:

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Is any other person or entity legally responsible for your medical bills (Title XIX, local government assistance programs, guardian or other insurance)? If so, list below:

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Are there other extenuating circumstances that impact your ability to pay your bill for laboratory services?

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I certify that the above information is true to the best of my knowledge.

____ ____________________

Patient Signature Date