SunMED Medical Solutions

Financial Hardship Form

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Insurance Carrier: _____

Annual Income: _____ Supplemental Income: _____

A. Have you applied for, or are you currently enrolled in, any kind of state, federal, or community assistance programs? If so, list below.

_____

_____

_____

B. Is any other person or entity legally responsible for your medical bill (e.g., Title XIX, local government assistance programs, guardian, other insurance)?

_____ _____

Name Relationship to patient

I certify that the above information is true to the best of my knowledge and understand that this information will be kept strictly confidential.

_____ _____

Patient Signature **Date**

We are sending this document to you because you have stated you desire to receive the medical equipment ordered by your physician, however, are unable to pay your portion of the charges not covered by your insurance company due to financial limitations. In order to consider waiving these charges to you, this form must be signed, dated and returned to us within 15 days of its receipt. If this form is not returned to us, or you have not contacted us within 15 days, the patient responsibility for this medical equipment will be your responsibility.

Return form to: SunMED Medical, Attention: Accounts Receivable, 36 West Route 70, Suite 214, Marlton, NJ 08053 or Fax to: 800-715-5422, Attention: Accounts Receivable. It may also be scanned and returned via email to: janet.billy@sunmedmedical.com

SunMED Medical Solutions

APPLICATION FOR BALANCE ADJUSTMENT
PLEASE PRINT AND COMPLETE IN ITS ENTIRETY

PATIENT INFORMATION: Name:_____ Address: _____ City:_____ State:_____ Zip:_____ Phone Number: (_____)_____ Date of Birth:_____ Marital Status:_____ Social Security Number:_____ Number of Dependents:_____	FOR OFFICE USE ONLY:
EMPLOYER INFORMATION: Name:_____ Address:_____ City:_____ State: _____ __ Zip:_____ Phone Number: (_____)_____ Position:_____ Years Of Employment: _____ years	

BE SURE TO ENCLOSE COPIES OF THE FOLLOWING:

- 1040 TAX RETURN - PAYROLL CHECK IF APPLICABLE
- SOCIAL SECURITY CHECK OR DECLARATION LETTER
-LIST OF ALL EXPENSES AND PROOF

FINANCIAL INFORMATION

	MONTHLY INCOME:	AMOUNT
	Monthly Income From Employer:	$
	Monthly Disability Income:	$
	Monthly SSI Benefits:	$
	Pension:	$
	Investments/Interest Income:	$
	Rental Income:	$
	Spouse's Monthly Income:	$
	Alimony/Child Support:	$
	Other Income:	$
	MONTHLY EXPENSES: PLEASE LIST (ONLY REOCCURRING) Please submit a copy of ALL monthly expenses (ex: Rent, Utilities, etc)	$

PATIENT PLEASE COMPLETE:

I certify that the information I provided is true, accurate, correct, and complete in all aspects. I have not falsified nor left out any pertinent information that would alter the determination of financial hardship which I am requesting from SunMED Medical Systems, LLC.

Patient's Name (Print)_____

Patient's Signature:_____

Date:_____