



## FINANCIAL ASSISTANCE APPLICATION

### How can we help you?

Banner Health understands that receiving medical care can sometimes include expenses that are unexpected and that you may need help navigating those. We have a financial assistance program and resources here to help you.

The first step in seeking this support is to complete this Financial Assistance application and provide the below- listed documentation. All information will remain confidential and will help guide our processes.

- Your completed financial assistance application.
- A complete copy of your prior year's federal income tax return.
  - If currently employed, copies of your last four consecutive payroll stubs for both the patient/guarantor and spouse.
  - If self-employed, a copy of your federal tax form Schedule C.
  - If retired and/or receiving Social Security, a copy of your SSA 1099 form.
- Copies of any outstanding medical bills including doctor bills, ambulance etc.
  - If you are currently uninsured, Banner Health will assist you in applying for state assistance, AHCCCS, Medicaid or Medi-Cal, and will include your determination notice.
- Residents of Colorado will need to apply for the Colorado Indigent Care Program (CICP).

The billing process does continue during this process, so it is critical to return this information as quickly as possible. Incomplete or missing information will delay the process. Please return completed application and required documents to:

Banner Health Surgery Center

Payment Support Financial Assistance

Attn: Payment & Support Operations

P.O. Box 29661-2107

Phoenix, Arizona 85038-9661

Email: [BSC.PaymentSupportOperations@atlashp.com](mailto:BSC.PaymentSupportOperations@atlashp.com)

Fax: 602-314-7902

Additional information on our Financial Assistance resources can be found on our [Banner Health Billing page](#). If you have questions about this process, please contact us at 866-670-4460, Monday - Friday from 8:00am - 5:00pm MST.



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### PATIENT INFORMATION

Facility name: \_\_\_\_\_

Account number(s): \_\_\_\_\_

Patient name: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home phone number: \_\_\_\_\_ Contact phone number: \_\_\_\_\_

### GUARANTOR INFORMATION

Guarantor name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home phone number: \_\_\_\_\_ Contact phone number: \_\_\_\_\_

### HOUSEHOLD INFORMATION

List all members of your household and indicate if they are a dependant. Remember to include yourself.

Name	Relationship	Age	Dependent (Yes or No)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



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I would like to participate in Banner Health's financial assistance program and understand all disclosed personal information is for the sole purpose of determining my eligibility. Banner Health will keep this secure and confidential.

The information I have provided is accurate to the best of my knowledge. It has been explained to me and I agree as a condition of my qualifying for financial assistance from Banner Health, should I qualify and receive assistance, any third party funding I receive or become eligible to receive, pursuant to ARS Sec. 33-931, et seq., Arizona's health care lien statute, or applicable statutes, may be considered and recovered by Banner Health to address and offset the financial assistance discount provided to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name(Print) -----

**ADDITIONAL COMMENTS:**This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.