SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AND APPLICATION

Return to: Banner Health c/o PBM PO Box 743711, Los Angeles, CA 90074-3711 BannerFAApplications@bannerhealth.com	Current Date: Patient Name: Birth Date: Facility: Date of Svc:

Instructions: Complete application and include the following documentation and return to address or email above.

**Not applicable for NHSC locations including: Fallon, NV, Femley, NV, Susanville, CA Payson Primary Care, AZ, Payson OBGYN, AZ and Maricopa, AZ

- Proof of income. Acceptable documents include:
  - If currently employed, copies of last three (3) most recent consecutive payroll stubs (patient, guarantor and spouse)
  - If self-employed, a copy of Federal tax form Schedule C or other proof of income and expenses
  - If retired and/or receiving Social Security, a copy of SSA 1099 form or reward letter**
  - If Unemployed, a copy of your prior year's federal income tax return, unemployment reward letter or self-declaration of income letter.**
  - Determination of State or government assistance (Medicaid/AHCCCS)**
  - If requested, copies of non-Banner medical bills**

Applicant/Guarantor Name: Social Security Number:**
Address:
Birth Date:
Phone Number:
Employer: Employment Status:
Length of Employment: Unemployed Date/Length:

Name:
Employer: Employment Status:
Birth Date:
Phone Number:

Name:	Relationship:	Birthdate: (mm/dd/yyyy)
2.		
4.		
6.		

Description:	Monthly Amount:
2.	$

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

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Current Date:
Patient Name:
Birth Date:
Facility:
Date of Svc:

Type of Debt / to Whom:	Unpaid Balance:	Monthly Payment:
2. (Hospital)	$	$
4. (DME/Home Care)	$	$
6.	$	$

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.

Responsible Party Signature: Date/Time:

Print Name:

Spouse or Partner Signature: Date/Time:

Print Name:

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