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 Patient Financial Services
Attn: Financial Assistance Department
P.O. Box 18
Phoenix AZ 85001

Additional information on our Financial Assistance resources can be found on our Banner Health Billing page.
If you have questions about this process or other billing processes, please contact us at 888-264-2127, Monday – Friday from 8:00am – 5:00pm MST.

Banner Health

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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)

Banner Patient Financial Services, PO Box 18 Phoenix, AZ 85001

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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:

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Banner Patient Financial Services, PO Box 18 Phoenix, AZ 85001

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