Financial Assistance Application

How can we help you?

Banner Health understands medical expenses may be unexpected and you may need financial assistance. We are here to help.

Please provide our billing office, Patient Financial Services, with this completed application and the necessary documents to determine how we may best assist you. Your information will remain confidential. Since our billing process will continue until a determination is made as to your eligibility for financial assistance, please return this information promptly. Our mailing address is: POB 18, Phoenix AZ 85001.

What is needed?

- 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)

How can you reach us?

We are available Monday through Friday from 8:00am to 5:00pm. You can call us at (480)684-7414 or toll free at 1(855)244-7460. You can also visit us in person at Banner Health 525 W. Brown Road, Mesa AZ 85201.

Sincerely,

The Financial Assistance Department

Banner Health Patient Financial Services

Financial Assistance Application

Banner Health. Making health care easier so life can be better.

PATIENT INFORMATION

Facility name:_____

Account number(s):_____

Patient name: _____ Social Security #:_____

Address:_____

City:_____ State:_____ Zip code:_____

Home phone number:_____ Contact phone number:_____

Email:_____

GUARANTOR INFORMATION

Guarantor name:_____ Social Security #:_____

Address:_____

City:_____ State:_____ Zip code:_____

Home phone number:_____ Contact phone number:_____

Email: _____

HOUSEHOLD INFORMATION

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

Name	**Relationship**	**Age**	**Dependant (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 that 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 other applicable statutes, may be considered and recovered by Banner to address and offset the financial assistance discount provided to me.

Signature:_____ Date:_____

Name (Print):_____

ADDITIONAL COMMENTS: