2801 W Main, Belleville, IL 62226
Phone: 866-710-7679 - Fax: 800-218-7670

MEDICARE FINANCIAL HARDSHIP EXCEPTION FORM

Patient:

Name: _____ SSN: _____ Pat No. _____

Address: _____

_____

Insurance:

Is the above patient covered by any health insurance? Yes ☐ No ☐

If Yes, name of Primary Insurance: _____

Benefits Coverage: _____

Secondary Insurance: _____

Benefits Coverage: _____

Based on Medicare law, we are required to attempt to collect any unpaid portion of the annual deductible and the copayment (co-insurance) from the beneficiary.

I have determined that, due to my financial hardship, I am unable to pay the outstanding portion of my deductible and/or co-payment. Due to my financial circumstances, please waive or discount my obligation for payment of charges for the following services:

Item: _____ Charge: _____ Date: _____

However, if in the future my financial situation has improved enough to enable me to pay, I will inform Direct Medical, INC.

Statement of Agreement: "I understand that Direct Medical Inc is waiving collection of the co-payment and deductible amounts in my case due to financial hardship. I also understand that Direct Medical, Inc can and will begin to collect on these charges should my financial situation improve."

Signature of Patient_____ Date:_____
(Guardian if Minor)