NEW ENGLAND TISSUE ISSUE

A Sonic Healthcare Dermatopathology Practice

Information for patients

Patient Financial Assistance Application

Thank you for using New England Tissue Issue for your medical laboratory needs.

New England Tissue Issue recognizes that laboratory medicine can be very expensive and bills can become burdensome for patients with limited financial means. We have developed a system to determine eligibility for discounts on your lab bill.

Please fill out the attached form completely and return to the Accounts Receivable Department:

New England Tissue Issue, 1822 North Main Street, Suite 302, Fall River, MA 02720
Attention: Director, Revenue Cycle

Please submit one of the following documents with the completed financial form:

- Copy of pay stubs for the past two months, or
- A letter from your employer indicating breakdown of income for the past two months, and
- Proof of income from any of the following sources: Social Security, Workers' Compensation, Welfare, Child Support, Disability, Unemployment Compensation, Alimony

Failure to provide documentation to verify income may result in denial of your assistance application. Applicants who do not meet the income guidelines may wish to inquire about alternate payment options that are available. Questions concerning this program or the application process should be directed to our Patient Accounting Department at (401) 214-9111. Information and application can be faxed to (833) 706-2437.

For additional information, please visit our website **www.netissueissue.com**

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New England Tissue Issue
Patient Financial Assistance Application

Date _____ Accession Number or Date of Service _____

Patient Last Name _____ First Name _____

Social Security Number _____ Date of Birth _____ Marital Status _____

Address _____ City _____ State _____ Zip Code _____

Home Telephone _____

Employer Name _____ Phone _____

City _____ State _____ Zip Code _____ Current Monthly Income _____

Was the patient covered by any insurance, Medicare, Medicaid or any other medical assistance for the date of service listed above? **Y N**
If so, give policy name, number and address on back of this form.

Please provide the following information for yourself and all dependents:
(All persons for whom you are financially responsible, living in the same house and related by blood, marriage or adoption) Use back of form for additional dependents.

Last Name _____ **First** _____ **Birth Date** _____ **Relationship** _____
Last 3 Months' Gross Income **$** _____ Last Year's Gross Income **$** _____

Last Name _____ **First** _____ **Birth Date** _____ **Relationship** _____
Last 3 Months' Gross Income **$** _____ Last Year's Gross Income **$** _____

Last Name _____ **First** _____ **Birth Date** _____ **Relationship** _____
Last 3 Months' Gross Income **$** _____ Last Year's Gross Income **$** _____

Last Name _____ **First** _____ **Birth Date** _____ **Relationship** _____
Last 3 Months' Gross Income **$** _____ Last Year's Gross Income **$** _____

I hereby authorize New England Tissue Issue to make any inquiries necessary to verify my eligibility for financial assistance. I understand falsification of this eligibility information will result in being responsible for all incurred charges and ineligibility for future financial assistance.

_____ _____
Signature Date

For internal use only:

Level _____ FPIL $w_____ Applicant Max $_____ Qualify _____%

Old Balance _____ New Balance _____

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1822 North Main Street, Suite 302
Fall River, MA 02720

www.netissueissue.com
P: 508.235.1118

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