UNINSURED PATIENT MEDICARE CARES ACT APPLICATION FOR COVID-19

The Families First Coronavirus Response Act or FFCRA allows for conducting COVID-19 testing and treatment for the uninsured individuals. Please complete the information below to ensure your eligibility for complete and full coverage of the testing provided today for the COVID-19 virus.

Date of Service: ____________________ **Patient MRN** (optional)**:** ____________________

First Name: ____________________ **Last Name:** ____________________

Date of Birth: ____________________ **Gender:** ☐ **Male** ☐ **Female**

***SSN** ____________________ **State of Residence:** ____________________

State Identification/Driver's License #: ____________________

*A SSN and state of residence, or state identification / driver's license is needed to verify patient eligibility. If a SSN and state of residence, or state identification / driver's license is not submitted, you will need to attest that you attempted to capture this information before submitting a claim and the patient did not have this information at the time of service.Claims submitted without a SSN and state of residence, or state identification / driver's license may take longer to verify for patient eligibility.

Acknowledge and Attest to Attempt on Collecting SSN or Identification Information:

(collector's initials)	(date)

Address: ____________________

City, St, Zip code: ____________________

**If the individual is unable or unwilling to provide their address, please add the address of the facility where the care was provided or other location that may be appropriate (e.g., shelter).

Patient Acknowledgement and Attestment:

By my signature below, I acknowledge and attest to not having any health insurance coverage of any kind, including federal and state health care programs such as Medicare and Medicaid or other insurance coverage such as insurance provided by a school or AFLAC.

____________________ ____________________

Patient or Representative Signature **Date**