Financial Hardship Application

Please complete the requested information below. All information provided is strictly confidential and will be used only for purposes of determining financial hardship. Please provide as much information as possible for Keystone Laboratory to consider when making its hardship determination.

Patient Information

Patient full name	Date of Birth	Phone
Address		
City	State	Zip

Insurance Information

Does the patient have health insurance coverage, including Medicare or Medicaid? If yes, please provide below.
____ Yes
____ No

Insurance Company Name		Subscriber ID
Insurance Claims Address (see back of card)		
City	State	Zip
Policyholder Name (if different than patient)	Policyholder Date of Birth	Policyholder Relationship to Patient

Financial Information

1. **Current annual household income:** _____
   Include information for all household members: gross salary, unemployment payment, disability, workers' compensation, social security benefits, supplemental (SSI) benefits, public assistance (TANF, SNAP, etc) or other income.

2. **Number of persons in household (including patient):** _____

3. **(Optional) Please list any extenuating circumstances that you would like to be considered (e.g. bankruptcy, job loss, etc)**

_____

_____

Certification

I hereby acknowledge that the above information is true and correct. I authorize Keystone Laboratory to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation for the above request. I understand that if I do not qualify, I will be notified and Keystone Laboratory will bill me. I hereby acknowledge that I am neither related to, nor employed by, the physician who ordered the testing.

_____

Patient Signature **Date**

Mail or fax completed applications to:
Keystone Laboratory ATTN: Patient Accounts
3 McDowell St, Asheville, NC 28801
Fax: 855-204-3222

Keystone Use Only:
Received Date: _____
Approved Date: _____
Initials: _____