Convenience ▪ Affordability ▪ Choice™

Byram HEALTHCARE

Complete and Return This Financial Hardship Application to Byram Healthcare:

Byram Healthcare
Attn: Financial Hardship Coordinator
3010 Woodcreek Drive, Suite A
Downers Grove, IL 60515

Byram Healthcare abides by the contractual and legal obligations of Medicare, Medicaid and any other governmental or commercial third-party payer or regulatory agency to collect charges, co-payments, co-insurance and deductible amounts owed by patients. Recognizing that circumstances may arise whereby an individual is unable to meet his or her financial obligations for services rendered, we have adopted a policy of screening requests for discounts, delayed payment plans and/ or forgiveness of debt based on individual circumstances. To do this, we must obtain certain financial and other personal information from you which will be considered and applied consistently in accordance with our established financial assistance protocol.

Please provide the information and documents listed below for each adult family member living in your household (and reported on your income tax return) to the best of your ability. All the information provided will be held confidential according to our privacy policy.

APPLICANT INFORMATION

Applicant Name: _____
Patient Name (if different than applicant): _____
Phone (Home): _____Phone (Mobile): _____ Email: _____
Address: _____
_____
Patient Date of Birth: _____ Number of Family Members in Household _____
Year of Tax Return (most recent year of federal tax return must be attached to application). _____

I certify under the penalty of perjury that all the information provided as a part of this financial assistance application is true and accurate. I understand that the information supplied in this application is subject to verification by Byram Healthcare and hereby authorize any holder of information supplied in this application to release such information to Byram Healthcare for purposes of this application. I further understand that failure to disclose information requested in this application or disclosure of erroneous information will cause the application to be denied. I also agree to apply for state or federal assistance prior to an award of financial assistance, if applicable. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by Byram Healthcare to take such action and will assign Byram Healthcare all amounts recovered up to the total amount of the outstanding balance on my bill.

_____ _____
Applicant Signature Date

_____
Relationship to Applicant (if not Applicant)