PATIENT FINANCIAL HARDSHIP APPLICATION

ARMO Diagnostics recognizes that circumstances arise where a patient may be unable to pay in full whether they are uninsured or have difficulty completing co-pays, co-insurance or deductible obligations. ARMO has adopted a hardship and financial support policy of validating requests for discounts or debt forgiveness. To qualify for this program, ARMO must verify your financial information which will be held confidential according to our privacy policy.

Patient Name: ____ SSN: __________________

Address: ____

Telephone No: ____________________________________ Patient DOB: ______________________

Number of dependents in household: ______________ Number in school: ______________________

Is the patient insured: YES NO

If yes, please list covered person, insurance carrier name, address, and phone number from the back of the insurance card, policy holder ID# and Group#

Financial Information:

Total gross yearly income $_______________________ (This includes W-2, unemployment or disability)

Household size: __________________________

BY MY SIGNATURE BELOW, I HEREBY ACKNOWLEDGE AND ATTEST THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE ARMO DIAGNOSTICS TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED. I ACKNOWLEDGE THAT COMPLETION OF THIS FORM DOES NOT GUARANTEE DISCOUNT, PARTICIPATION IN PAYMENT PLAN, OR DEBT FORGIVENESS.

Patient Name (Print): ____ Date: _______________

Patient Signature: ____ Date: _______________

SUBMIT THIS SIGNED APPLICATION ALONG WITH ANY DOCUMENTATION TO:

ARMO DIAGNOSTICS, LLC
ATTN: BILLING DEPARTMENT
7550 HWY 107
SHERWOOD, AR 72120
FAX: (501) 423-8758
BILLING@ARMODIAGNOSTICS.COM

For Internal Use Only:

Reviewed by:	Process Date:
Approval/Denial Reason:	Total Owed: