

Financial Hardship Waiver Application

Please complete this infor	mation:	
Date:		 
Patient Name:		 
Patient DOB:		 
Patient address:		 
Patient policy number:		
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Dear CareCentrix Patient,

Per your request, attached is a copy of the CareCentrix financial hardship waiver application. Please take the time to fill out the application completely, attach all supporting documentation and mail to:

CareCentrix PO Box 30723-3723 Tampa, FL 33630

All required documentation must be received within 30 days from the date of this letter. If you do not respond with the required documents within 30 days or pay the outstanding amounts due, your account may be forwarded to an outside collection agency. Your completed application and documentation will be reviewed, and you will be notified of the determination. This process usually takes approximately 4 to 6 weeks. There is a tool available here <a href="https://www.carecentrix.com/patients/financial-hardship-calculator">https://www.carecentrix.com/patients/financial-hardship-calculator</a> that may help you calculate your potential eligibility.

If you have any further questions or concerns, please contact Patient Services at 800-808-1902.

Sincerely,

CareCentrix



Dear CareCentrix Patient, Please fill in the below information below for your Financial Hardship Waiver Application.

Patient name:Date of Birth:Phone Number:Social Security Number:Patient relationship:	
FRP:	
Employer:	
Address of financially responsible Party:	
Number of Dependents (including patient/spouse):	
Self/Spouse	
Annual income (Gross)	
Gross Income (pay)	
Interest/Dividends	
Pension	
Benefits (Social Security)	
Unemployment, VA, MA	
Alimony, Support, Other	
Annual total	
There is a tool available here <u>https://www.carecentrix.c</u>	om/patients/financial-hardship-calculator

that may help you calculate your potential eligibility.

**Required documentation**: <u>Copies of previous 90 days' pay stubs and any form of income on all claimed</u> <u>dependents as well as the most current income tax returns</u>. CareCentrix must receive this application and all supporting documentation within 30 days or this application will be denied. You must include documentation reflecting contact with and determination from Medicaid, Social Services, Associate Assistance Plans, Welfare, etc.

I certify that the above information is true and accurate. Additional documentation to verify income may be required.

Patient Signature: Date:	
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