Athena Alliance Program Patient Financial Assistance Application

Patient Name ______________________________ Telephone number ____________________

Address ______________________________ Date of birth ____________________

City ____________________ State ____________________ Zip code ____________

Does the patient have medical insurance coverage? ☐ Yes ☐ No

If "Yes," please list responsible party information (If possible, include a copy of insurance card)

Insurance company name ______________________________ Policyholder name ____________________

Insurance company address ______________________________ Policyholder ID number ____________________

Insurance company phone number ______________________________

Current total annual gross household income $ ____________________

Total household income includes the following for all household members: gross salary, unemployment compensation, disability, worker's compensation, Social Security and/or supplemental (SSI) benefits, public assistance (TANF, SNAP, etc.), and other income.

Number of family members in household supported by the above income ____________________

Total household income is the tax filer, their spouse if they have one, and their tax dependents.

Optional: Please advise of any special circumstances that you would like us to consider. If you need additional space, please write on the back of this form or use a separate sheet of paper.

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I hereby acknowledge that the above information is true and correct. I authorize Athena Diagnostics 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 Athena Diagnostics will bill me. I hereby acknowledge that I am neither related to nor employed by the physician who ordered the testing.

Responsible party (print) ______________________________ **Date** ____________________

Responsible signature ______________________________

For official use only

Bill number	Amount $	Approved	Denied
Date received			
Supervisor signature			

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