

Financial Assistance Request

Advanced Medical Management

Intercity Radiology P.C. & Advanced Medical Imaging Billing Office

925 Highland Blvd, Suite 1180 Bozeman, MT 59715

Phone: (406) 587-8631 Fax: (406) 587-1343 office@intercityradiology.com

YOUR ACCOUNT NUMBER WITH US:

PATIENT NAME:

PATIENT ADDRESS:

PATIENT CITY, STATE ZIP:

PATIENT PHONE #:

PATIENT SSN#:

PATIENT DATE OF BIRTH:

EMPLOYER NAME:

EMPLOYER PHONE#:

HOUSEHOLD FINANCIAL INFORMATION

MONTHLY INCOME

TOTAL HOUSHOLD INCOME	
UNEMPLOYMENT INCOME	
CHILD SUPPORT INCOME	
OTHER (ALIMONY, PUBLIC ASSISTANCE BENEFITS, ETC.)	
NUMBER OF FAMILY MEMBERS LIVING IN YOUR HOUSEHOLD	
TOTAL MONTHLY INCOME	\$ _____

MONTHLY EXPENSES

HOUSING (RENT,MORTGAGE)	
HOUSEHOLD EXPENSES (GAS, FOOD, UTILITY ,ETC.)	
MEDICAL EXPENSES	
OTHER EXPENSES (LOANS, CREDIT CARDS, ETC.)	
INSURANCE PREMIUMS (PAID BY YOU)	
TOTAL MONTHLY EXPENSES	\$ _____

Has any other hospital or medical office recently written off or discounted their bill to you?

Yes

No

If Yes, who gave you the discount? _____

If available please supply any of the following:

Last Years Federal Tax Return, including all schedules

Most Current Wage Stub

Unemployment Benefit Stub

I certify that the information submitted herein is true and accurate to the best of my knowledge. I understand that this application is made so Advanced Medical Management can judge my eligibility for a discount based on the financial assistance sliding scale program criteria. If any information proves to be untrue, I understand that AMM may re-evaluate my financial status and take whatever action becomes appropriate. All information provided is subject to verification, may include a credit check, or require additional information.

SIGNATURE OF PERSON REQUESTING FINANCIAL ASSISTANCE

DATE

