LOST RIVERS Medical Center

PATIENT FINANCIAL SUPPORT APPLICATION

Patient Name:		***SSN:**	
Address:	**City:**	**State:**	**Zipcode:**
Phone Number:		**DOB:**	

MEMBERSHIP

Does the patient have health insurance? **No** ☐ **Yes** ☐

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

Lost Rivers Health Account Number:
(Required)

Insurance Carrier Name:	**Phone Number:**
Address:	
Policyholder Name and ID#:	

FINANCIAL INFORMATION (ALL VALUES SHOULD REFLECT YEARLY AMOUNTS FOR ENTIRE HOUSEHOLD)

Financial

Total Gross Yearly Income $:_____

Household Size:_____
(Number of people who contribute to or are dependent on your household income). Your application may be subject to audit or request for additional documentation.

(Optional) Please advise of any extenuating circumstances that you would like us to consider. If you need additional space, please write on the back of this form or attach a separate piece of paper.

_____

_____

I hereby swear under penalty of perjury under the laws of the United States that the above information is true and correct. I authorize Lost Rivers Medical Center to verify the above information for the sole purpose of assessing financial need. I understand that if I do not qualify, I will be notified and Lost Rivers Medical Center will bill me. I have agreed to notify Lost Rivers Medical Center if my financial condition changes or improves.

Patient Name (Print):_____Date:_____

Patient Signature:_____Date:_____

Responsible Party Signature:_____Date:_____

Submit this signed Agreement to:

Lost Rivers Medical Center
ATTN: Financial Support Services
PO Box 145
Arco, ID 83213

For more information contact:

Lost Rivers Medical Center
Financial Support Services
Phone: (208) 252-7654
Fax: (208) 527-3105

FOR OFFICE USE ONLY

Process Date:	Total Owned:	# of Accounts:	
% Approved:		Beginning Date:	Expiration Date:
Processor Last Name:		Denial Reason:	
Approver Name:		Approver Signature:	

* Optional