CAIRO DIAGNOSTICS

Information for patients

Patient Financial Assistance Application

Thank you for using Cairo Diagnostics for your medical laboratory needs.

Cairo Diagnostics recognizes that laboratory medicine can be very expensive and bills can become burdensome for patients with limited financial means. We have developed a system to determine eligibility for discounts on your lab bill.

Please fill out the attached form completely and return to the Billing Department:

Cairo Diagnostics, 244 Westchester Avenue, Suite 310, White Plains, NY 10604

Email: billing@cairodiagnostics.com
Fax: 914.468.6172

Please submit one of the following documents with the completed financial form:

- Photocopy of pay stubs for three months before the date of service for all working household members.
- A letter from an employer indicating a breakdown of gross income, by month, for two months before the date of service for all working household members.

OR

- Proof of income from previous year's Tax Return, current year W2, Social Security, Workers' Compensation, Welfare, Child Support, Disability, Unemployment Compensation, or Alimony for all adult household members.

Failure to provide documentation to verify income may result in denial of your assistance application. Applicants who do not meet the income guidelines may wish to inquire about payment plan options that are available. Questions concerning this program or the application process should be directed to our Billing Department at **914.339.5000**.

For additional information, please visit our website **www.cairodiagnostics.com**

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Cairo Diagnostics
Patient Financial Assistance Application

Date ______ Accession Number or Date of Service ______

Patient Last Name ______ First Name ______

License Number ______ Date of Birth ______ Marital Status ______

Address ______ City ______ State ______ Zip Code ______

Contact Telephone ______

Employer Name ______ Employer Phone ______

City ______ State ______ Zip Code ______ Current Monthly Income ______

Was the patient covered by any insurance, Medicare, Medicaid or any other medical assistance for the date of service listed above? **Y** **N**
If so, give policy name, number and address on the back of this form.

Please provide the following information for yourself and all dependents:
(All persons for whom you are financially responsible, living in the same house and related by blood, marriage or adoption) Use back of form for additional dependents.

Person(s) Per Household ______

Last Name ______ **First** ______ **Birth Date** ______ **Relationship** ______
Last 3 Months' Gross Income **$** ______ Last Year's Gross Income **$** ______

Last Name ______ **First** ______ **Birth Date** ______ **Relationship** ______
Last 3 Months' Gross Income **$** ______ Last Year's Gross Income **$** ______

Last Name ______ **First** ______ **Birth Date** ______ **Relationship** ______
Last 3 Months' Gross Income **$** ______ Last Year's Gross Income **$** ______

Last Name ______ **First** ______ **Birth Date** ______ **Relationship** ______
Last 3 Months' Gross Income **$** ______ Last Year's Gross Income **$** ______

I hereby authorize Cairo Diagnostics to make any inquiries necessary to verify my eligibility for financial assistance. I understand falsification of this eligibility information will result in being responsible for all incurred charges and ineligibility for future financial assistance.

______ ______
Signature Date

For internal use only:

Level ______ FPIL $w______ Applicant Max $______ Qualify ______%

Old Balance ______ New Balance ______

A ProPath Services, LLC Laboratory

Cairo Diagnostics,
a ProPath Services, LLC Laboratory
244 Westchester Avenue, Suite 310
White Plains, NY 10604

www.CairoDiagnostics.com
P: 914.339.5000

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