PATIENT FINANCIAL SUPPORT APPLICATION

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

MEMBERSHIP

Does the patient have medical coverage? No ☐ Yes ☐

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

Millennium 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 $:__________ (Include pay stub, W-2, unemployment or disability statement, or other verification of 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.

I hereby swear under penalty of perjury under the laws of the United States that the above information is true and correct. I authorize Millennium Health 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 Millennium Health will bill me. I have agreed to notify Millennium Health if my financial condition changes or improves.

Patient Name (Print): ____________________ Date: __________

Patient Signature: ____________________ Date: __________

Responsible Party Signature:____________________ Date: __________

Submit this signed Agreement to:

Millennium Health, LLC ATTN: Financial Support Department
16981 Via Tazon, San Diego, CA 92127

For more information contact Millennium Health:

Phone: (877) 451-7337 Fax: (858) 433-5844

FOR OFFICE USE ONLY

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

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