Financial Hardship Waiver Application

Please complete this information:
Date: _____
Patient Name: _____
Patient DOB: _____
Patient address: _____
Patient policy number: _____

Dear CareCentrix Patient,

Per your request, attached is a copy of the CareCentrix financial hardship waiver application. Please take the time to fill out the application completely, attach all supporting documentation and mail to:

CareCentrix
PO Box 30723-3723
Tampa, FL 33630

All required documentation must be received within 30 days from the date of this letter. If you do not respond with the required documents within 30 days or pay the outstanding amounts due, your account may be forwarded to an outside collection agency. Your completed application and documentation will be reviewed, and you will be notified of the determination. This process usually takes approximately 4 to 6 weeks. There is a tool available here https://www.carecentrix.com/patients/financial-hardship-calculator that may help you calculate your potential eligibility.

If you have any further questions or concerns, please contact Patient Services at 800-808-1902.

Sincerely,

CareCentrix

Dear CareCentrix Patient,

Please fill in the below information below for your Financial Hardship Waiver Application.

Patient name: _____
Date of Birth: _____
Phone Number: _____
Social Security Number: _____
Patient relationship: _____
FRP: _____
Employer: _____
Address of financially responsible Party:
_____
Number of Dependents (including patient/spouse): _____

	Self/Spouse
Annual income (Gross)	_____
Gross Income (pay)	_____
Interest/Dividends	_____
Pension	_____
Benefits (Social Security)	_____
Unemployment, VA, MA	_____
Alimony, Support, Other	_____
Annual total	_____

There is a tool available here https://www.carecentrix.com/patients/financial-hardship-calculator that may help you calculate your potential eligibility.

Required documentation: Copies of previous 90 days' pay stubs and any form of income on all claimed dependents as well as the most current income tax returns. CareCentrix must receive this application and all supporting documentation within 30 days or this application will be denied. You must include documentation reflecting contact with and determination from Medicaid, Social Services, Associate Assistance Plans, Welfare, etc.

I certify that the above information is true and accurate. Additional documentation to verify income may be required.

Patient Signature: _____ Date: _____