Financial Assistance Application

HEALTHTRACK

Thank you for your interest in our Financial Assistance Program. For patients or guarantors who meet the eligibility requirements, HealthTrack may offer a discount or full waiver of financial responsibility for applicable lab testing services. To apply for the program, please complete the below form and provide one or more of the required proof-of-income documents.

Applications will be considered on a case-by-case basis. Once we have received your completed application and documentation, please allow approximately 2 weeks for your application to be processed. Applying for Financial Assistance does not guarantee reduced charges. Do not make payments until you receive notification regarding the status of your application.

If you have any questions about this application, please contact HealthTrack's Billing Support team at ***844-218-3097*** or email ***patientinquiries@HealthTrackRx.com***.

1. Applicant Information

Applicant Name (Last, First, Middle Initial)			Date of Birth
Street Address	City	State	Zip
Email Address	Phone Number	Relationship to Patient (Tested Individual) ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other _____	

Lab Test Identifier (Please provide at least ONE)

Account Number	Sample ID	Patient Name & Birthdate ☐ Same as Applicant

2. Financial Information

A. Do you have any health insurance that covers laboratory testing or other health services? If so, please list below:

	Insurance Company Name	Policy or Member ID Number	Group Number	Provider Services Phone Number
1.				
2.				

B. What is your household annual income?
(Please include all sources of income, including but not limited to Salary/Wages, Social Security, WIC/SNAP/Disability/Other Benefit Programs, Income from Retirement or Other Savings Accounts and/or Child Support)

$ _____

C. Number of family members in household:

_____

3. Financial Information

To be considered for financial assistance, documents demonstrating proof of income are required. Please submit copies of documents with this application. Documents will not be returned. ***Please do not send original documents.***

Acceptable documents demonstrating proof of income include the following. Please check off which document(s) you are providing with your application:

☐ Income Tax Returns ☐ W-2 Forms ☐ Recent Pay Stubs ☐ Social Security Checks, Unemployment, or other benefit payments

☐ Other (please describe): _____

4. Applicant Attestation

I understand that the information I submit is subject to verification, and I give HealthTrack permission to verify and use this information to determine my financial assistance eligibility. I understand that if I do not qualify, I may be responsible for payment of invoices issued by HealthTrack.

Applicant Signature: _____ Date: _____

HEALTHTRACK ONLY

☐ APPROVED

☐ DENIED

Reviewed By: _____

Date: _____