Tidwell Rx Pharmacy

IMPORTANT
Please read the following:

FINANCIAL HARDSHIP APPLICATION*

If Medicare requirements are met, Medicare will pay for 80% of the equipment and/or supplies you have requested. Unless you have Secondary/Supplemental Insurance that pays the co-payment and/or deductible, **Medicare requires that YOU PAY the deductible and/or applicable copays.**

If you are on a limited income, Medicare may let us reduce or waive these payments if you provide sufficient information to determine your financial need and sign this form.

The following information will remain Confidential. You must fill out the application to the best of your ability. Please provide amounts for patient only.

1. Full Name:_____D.O.B_____

2. Approximate Total Monthly Income: $_____

   a. Employment:_____(write N/A if not working)
   b. Social Security: _____
   c. 401K, IRA: _____
   d. Investments: _____
   e. Other: _____

3. Approximate Total Monthly Expenses: $_____

   a. Rent/Mortgage Payment: _____
   b. Car Payment: _____
   c. Groceries: _____
   d. Utilities: _____
   e. Medical Expenses: _____
   f. Other: _____

If you are enrolled In State Medicaid, please complete information below:

State: _____

Medicaid #: _____

Please attach any additional documentation you fill would assist us in evaluating your case (Ex: utility bills, rent, pay stubs, w2, etc)

Please Sign Below:

DUE TO MY LIMITED INCOME, AN OUT-OF-POCKET EXPENSE FOR MY SUPPLIES WOULD BE A FINANCIAL HARDSHIP FOR ME.

(The above information is accurate and is being provided for the purpose of allowing Tidwell Rx Pharmacy to determine whether payments would be a hardship for me. I will inform you if my financial circumstances improve.)

Patient Name:_____**Date:** _____

Signature:_____**Medicare ID: #** _____

*This document hereby serves as an application for approval into our assistance program. This application does not guarantee approval in anyway. For questions about this form, please call our billing offices, 1-800-852-7405

*Office Use Only: Approved: _____ Denied: _____ Payment Plan: _____