ARTHEON MEDICAL

Financial Hardship Waiver Qualification

Name of Beneficiary: _____ **MBI#:** _____ **DOB:** _____

Address: _____

City: _____ **St:** _____ **Zip:** _____ **Phone:** _____

Does this Beneficiary have State Medicaid? **Y** ☐ **N** ☐ **State:** _____

**If yes, stop here. You may automatically close secondary balances if Medicaid does not reimburse.*

Waiver Qualification

1. Does the patient have any secondary insurance? If yes, need name, ID# and address off of card:

2. Are there any family members, agencies or organizations that you may contact that will assist you in covering your deductible and/or co-insurance payment (e.g. local welfare agency, guardian, relative)? If yes, explain:

I believe that I am a low income user of durable medical equipment which I am renting from **Artheon Medical**. I understand that I am responsible for payment of my deductible and the 20% non-deductible portion of my Medicare and private insurance coverage. I represent to Artheon Medical that if I were required to pay all of my deductible and coinsurance portion of the monthly equipment rental or sales, I would have to deny myself needed medical services. I, therefore, request waiver of $_____, of my deductible and/or co-insurance portion, so that I shall not be required to pay all of the deductible and/or coinsurance charge otherwise payable by the beneficiary under Federal Health Care Financing Administration (HCFA) regulations. I will remain responsible for $_____ dollars per month. I agree that if at any future time my financial status should change or I obtain secondary insurance, I will contact them to inform them of the change. At present, I have no other insurance to cover the balance of these or future charges.

This waiver will automatically expire in one (1) year, following the date of my signature, without my express revocation. Continued waiver of coinsurance and/or deductible beyond the one year covered by this waiver shall require a subsequent waiver.

Signature of Beneficiary: _____

Signature of Beneficiary (or authorized caregiver if beneficiary unable to sign)

Relationship: _____

Relationship to beneficiary, if beneficiary unable to sign

Date of Signature: _____

**This waiver will automatically expire in one (1) year, following the date of my signature, without my express revocation. Continued waiver of coinsurance and/or deductible beyond the one year covered by this waiver shall require a subsequent waiver.*