BUTLER MEDICAL PROVIDERS

PHYSICIAN DIVISION

FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME: _____

DATE OF SERVICE: _____

ACCOUNT NUMBER: _____

Listed below are the documents that are needed to complete your Financial Assistance Application.

This application MUST be completed and returned within 30 days to Butler Medical Providers.

Please provide the following documents to verify income:

___1040 TAX RETURN (MOST RECENTLY FILED) (FRONT PAGE OF FEDERAL INCOME TAX RETURN INCLUDING NUMBER OF DEPENDENTS CLAIMED.)
___SOCIAL SECURITY BENEFITS FOR THE CURRENT YEAR (COPY OF BANK STATEMENT IF DIRECTLY DEPOSITED)
___UNEMPLOYMENT BENEFITS (COPY OF UNEMPLOYMENT DETERMINATION
___CHILD SUPPORT PAYMENTS
___PAYSTUB(S) LAST 30 DAYS
___PENSION (COPY OF BANK STATEMENT IF DIRECTLY DEPOSITED)
___DISABILITY/ WORKERS COMPENSATION
___ALIMONY
___PROOF OF ANY OTHER SOURCES OF INCOME
___MEDICAL ASSISTANCE DETERMINATION LETTER
___NUMBER OF DEPENDENTS CLAIMED FOR TAX PURPOSES

SIGNATURE_____WITNESS_____

INCOME PREVIOUS TAX YEAR: _____%APPROVED_____

INCOME CURRENT TAX YEAR: _____ APPROVED BY_____

PLEASE SIGN AND RETURN FORM AND DOCUMENTS TO BUTLER MEDICAL PROVIDERS AS SOON AS POSSIBLE. ANY QUESTIONS PLEASE CONTACT OUR OFFICE AT 724-284-7458 OR 724-284-4022 MONDAY THROUGH FRIDAY 9:00AM TO 5:00PM YOU CAN ALSO EMAIL YOUR APPLICATION TO BMPpatientaccounts@ButlerHealthSystems.org OR MAIL YOUR APPLICATION TO BUTLER MEDICAL PROVIDERS P.O. BOX 447 500 GRANT AVENUE EAST BUTLER, PA 16029 ATTN: KATHY SMITH

PO Box 447
500 Grant Avenue, 2nd Floor
East Butler, PA 16029

724-284-7470
724-284-4470 (fax)

ButlerHealthSystem.org