VAP DIAGNOSTICS PATIENT ASSISTANCE

PATIENT ASSISTANCE PROGRAM APPLICATION - TO BE COMPLETED BY PATIENT

1. Please mail or fax two of the following items with application:
   - Copy of last year's W2 form
   - Copy of page 1 from last year's IRS Form 1040
   - Copy of your most recent pay stub(s)
2. If you have insurance coverage, please provide copy of health insurance card.

Mail to: VAP Diagnostic Patient Pay
MSC#728
P.O. BOX 830674
Birmingham, AL 35283-0674
Vicor# 830721
P: 866-377-4266 | F: 216-464-5588
E: billing@vapdiagnostics.com

PATIENT INFORMATION

Last Name (Please Print)	First		Middle Initial
Telephone Number	Date of Birth		
Street Address	City	State	Zip

Invoice Number(s)__________ Lab Code:__________

Please complete all information accurately. The signature of the patient or patient's guardian is required.
<u>Please make sure to attach required supporting documentation.</u>

1. Does the patient have sufficient resources to pay for the testing and/or the deductible and coinsurance?
   ☐ Yes *If answer is "Yes", you are financially responsible for payment.*
   ☐ No *If answer is "No", complete form below.*

2. Is the patient covered by any form of health insurance, commercial or government?
   ☐ Yes ☐ No *If answer is "Yes", list:*

   Insurance Company Name:__________
   Address: __________
   Member ID: __________
   Other Source:__________

3. Patient/legal guardian's monthly resources:

Salary	Social Security
Cash/Welfare Payment	Family Contribution
Income from Savings Accounts, CDs, etc.	Other
	TOTAL: $

4. Number of family members in household:__________

I hereby acknowledge that the above information is true and correct according to the best of my knowledge and belief. I also authorize the release of any and all financial records necessary to verify the above information. I understand that if I do not qualify, I will be notified, and VAP Diagnostics will bill me. I hereby acknowledge that I am neither related to nor employed by the physician who ordered the testing.

Patient Name (Print):__________ **Responsible Party Name (Print):** __________

Responsible Party Signature: __________ **Date:**__________

OFFICE USE ONLY

Bill Number	Amount $	Approved	Denied

Date Received: __________ Supervisor Signature: __________