



Physicians Billing Service

FINANCIAL APPLICATION

Guarantor #:

Dear \_\_\_\_\_:

A financial application and checklist are attached. Place an "x" on the checklist next to the items you are sending.

**Remember, you must complete the entire form. Please attach all documents and return the application. If you do not return the application, your account may go to a collection agency.** If you have any questions, call us **BEFORE** you mail your application. The telephone number is 314-273-0880 Monday through Friday 8:00 AM - 4:30 PM.

**Walk-in patients only from 8:00 a.m - 4:00 p.m. (Please do not mail applications to this address):**

WashU Medicine Physicians Billings Service  
Center for Advanced Medicine  
WU Financial Counselors Office, Third Floor (behind radiology registration desk)  
4921 Parkview Place  
St. Louis, MO 63110

**You may fax your application to 844-395-8822.**

**To mail applications: (drop box is not a physical location to drop off)**

WashU Medicine Physicians Billing Service  
660 South Euclid  
Mailstop Code: 8239-87-1800  
St. Louis, MO 63110

**Inquiries for the status of your financial assistance application (please allow 30 days) email: [PBSteam@email.wustl.edu](mailto:PBSteam@email.wustl.edu), My Chart message or call 314-273-0500 or 314-273-0880.**

Sincerely,

*WashU Medicine Physicians Billing Service*

**FINANCIAL ASSISTANCE CHECKLIST*****PLEASE READ CAREFULLY***

**All requested documentation must be attached to your application. If you are married, you must include your spouse's information. If the patient is a minor, you must include both parent's information:**

- Copy of your most recently filed Federal tax forms "All Federal Forms Only". If you did not file your most recent Federal taxes, a non-filing transcript needs to be obtained and submitted from the IRS.
- Copies of W2's from current employer(s) for both patient and spouse.
- 1099 forms received for pension/retirement earnings, dividends, IRA disbursements, etc.
- All schedules prepared with your taxes (A, B, C, D, E, F, forms 4797, 8829, etc.)  
(Please do not submit your State taxes, only Federal taxes are required)

**If you did not file taxes, please call the IRS (800-908-9946) and request a "non-filing transcript." Send us a copy of this transcript. You can obtain a copy online from IRS.gov option to print or request a copy by mail.**

**If you receive any of the following, please include copies of:**

- Unemployment compensation
- Social Security benefits- Social Security Award Letter or bank deposit as proof of Disability benefits
- Letter from employer stating unpaid medical leave
- Alimony/Child support
- Signed letter from the person(s) providing financial help
- Two most recent paycheck from your employer(s) for both patient and spouse
- Pension benefits (bank statement or statement from company)
- Food stamps/ Housing/ Utility Assistance letter
- If you are a student, copy of school schedule/financial assistance/scholarship information
- If you are not employed, provide proof that no income is earned or last date of employment (from the division of employment services from the year 2018-present)

**ILLINOIS:** 800-244-5631

**MISSOURI:** 314-340-4950

**Before we process your application, if you do not have any insurance, please apply for Medicaid if you have not already done so:**

**Illinois:** 1-800-843-6154; or visit local DHS office    **Missouri:** 1-855-373-9994; or visit local DHS office

- If you have been denied Medicaid or IPA, send us a copy of your denial letter.
- If you have been approved for Medicaid or IPA and have a Spenddown requirement, you must send us a copy of your Spenddown letter provide your caseworker's name, phone number and fax number (if available)
- **If you have applied for or been approved for Medicaid or IPA, please provide the following:**

\_\_\_\_\_  
Caseworker name

\_\_\_\_\_  
Caseworker phone

\_\_\_\_\_  
Caseworker fax

- If the charges are the result of a motor vehicle accident, your auto insurance must be provided and billed prior to applying for financial assistance. If there is no insurance coverage, please include the insurance letter or police report indicating no insurance coverage.
- If you are a Victim of Crime, a police report must be filed and an application must be completed with Crime Victims, before applying for financial assistance.
- If the charges result from an accident, such as a fall at a store, home, place of employment or any other type of business, their liability insurance must be billed prior to applying for financial assistance.
- Not all services are covered under financial assistance. Co-pays are excluded from financial assistance and are expected to be paid at the time of service. Some chemotherapy drug charges only allow a maximum of 40% discount, if you are approved for financial assistance.

**I have completed my entire application and attached all required documentation.**

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/guardian signature

\_\_\_\_\_  
Date

**Please return this signed form with your Application for Assistance to:**

WashU Medicine Physicians Billing Service  
Attn: FAP Department  
WashU Medicine  
660 S Euclid Ave.  
Mailstop Code: 8239-87-1800  
St. Louis, MO 63110-1093

**PLEASE ENCLOSE YOUR MOST RECENT FEDERAL TAX RETURN**

<b>Date Sent:</b>			
<b>Please Return By:</b>			
<b>Date Returned:</b>		<b>Phone #:</b>	
<b>Patient Name</b>	<b>Date of Birth-age</b>	<b>Marital Status: S M W D</b>	<b>Patient Social Security#</b>
<b>Patient</b>		<b>Person Responsible for Bill (if minor)</b>	<b>Relationship</b>
<b>Street</b>		<b>Name</b>	
		<b>Street</b>	
<b>City, State, Zip</b>		<b>City, State, Zip</b>	
<b>Phone: (     )</b>		<b>Phone: (     )</b>	
<b>Patient's Employer</b>			
<b>Occupation</b>			
<b>If Unemployed, Name of Last Employer- please refer to checklist</b>			
<b>How Long Unemployed</b>			

LIST BELOW ALL MEMBERS OF HOUSEHOLD (Exclude Patient)		
Name	Age	Relationship to Patient

<b>Do you have health insurance coverage available?</b>		<b>Yes</b>	<b>No</b>	<b>Have you applied for Medicaid or Gateway to Better Health?</b>	<b>Yes</b>	<b>No</b>	
<b>If "yes," is it available for this date of service? If not, why not?</b>				<b>Date applied:</b>			
<b>If no insurance coverage, please indicate reason for lack of coverage:</b>				<b>Denial Date:</b>			
<b>Cost?</b>				<b>Reason for Denial:</b>			
<b>Pre-Existing Condition?</b>		<b>Other, Please Describe</b>		<b>Have you applied for Insurance through Healthcare Exchange/ Obamacare?</b>		<b>Yes</b>	<b>No</b>
<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>If you were exempt from applying for insurance, please attach a copy of the letter and/or 4029 form.</b>			

<b>MONTHLY INCOME:</b> * Attach Copy of Proof of Income			
	<b>Patient</b>	<b>Spouse</b>	<b>Other</b>
<b>Wages (Gross) *</b>			
<b>Social Security *</b>			
<b>Pensions *</b>			

<b>Unemployment/Work Comp</b>			
<b>Alimony/Child Support</b>			
<b>Government Assistance</b>			
<b>Disability Payments *</b>			
<b>Strike Benefits</b>			
<b>Scholarships/Grants *</b>			
<b>Dividends/Interest</b>			
<b>Other, List</b>			

<b>EXPENSES</b>	<b>MONTHLY</b>	<b>BALANCE DUE</b>	<b>ASSETS – VALUE</b>	<b>PATIENT (Joint)</b>
Mortgage or Rent Pmt			Savings	
Car Payment			Checking	
Utilities (Gas, Electric, Water)			Money Market	
Cable			CD's	
Phone			Investments, Stocks, Bonds	
Cell Phone			Home(Market Value)	
Food			Cars/ Motorcycles	
Child Care			Make/Model	
Clothing			Year	
Insurance (Auto, Life, Health)			Car #2	
Gas/Transportation			Make/Model/Year	
Recreation			Car #3	
Pharmaceuticals/Medications			Make/Model/Year	
Physicians			Boats / Other	
Hospitals			Other Property/Real Estate	
Other Medical			IRA, 401k, 403b	
Credit Cards			<b>LIABILITIES</b>	
			Home Loan	
Other Expenses (Describe)			Auto Loan	

**PLEASE ATTACH ANY OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION.**

I CERTIFY THAT THE INFORMATION PROVIDED IN CONNECTION WITH THIS FINANCIAL ASSISTANCE APPLICATION IS CORRECT AND COMPLETE. I AUTHORIZE VERIFICATION OF ANY INFORMATION AND I UNDERSTAND THAT ADDITIONAL DOCUMENTATION MAY BE REQUESTED. I ALSO AUTHORIZE THE HOSPITAL AND WASHINGTON UNIVERSITY TO SHARE (A) THIS FORM AND ITS ATTACHMENTS, (B) OTHER FINANCIAL INFORMATION THE HOSPITAL OR WASHINGTON UNIVERSITY MAY HAVE, AND (C) DETAILS OF THE FINANCIAL ASSISTANCE PROVIDED, WITH THE HOSPITAL OR ANY PHYSICIAN OR HEALTH-CARE PROVIDER (OR THEIR AGENTS) ALSO CARING FOR ME. I UNDERSTAND THAT IF ANY INFORMATION IS FOUND TO BE FALSE, THE FINANCIAL ARRANGEMENT OR ASSISTANCE MAY BE VOIDED.

**Patient/Responsible Party Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_