Hardship Letter

LifeCare Therapy Services has received a request for an adjustment to an account balance due for services rendered. The balance is due to one of the following reasons:

1. Insurance did not pay as expected.
2. Insurance was terminated or no valid coverage existed at the time services were rendered.
3. The amount was applied to a deductible or co-insurance and exceeds your abiity to pay.

In accordance with § 310 and 42 CFR 413.80, a provider must be able to document that it has pursued all reasonable collection efforts before considering an account for bad debt. In order to be considered for a financial hardship, we must have a signed letter from the responsible party attesting to the fact that a financial hardship exists and there is no ability to pay the balance that is due on this account.

If these statements are true and you are experiencing a financial hardship and are unable to pay the balance due on your account or make payments on the balance due, please complete the Attestation Statement included with this form. The letter must be returned in order for the request to be considered.

If you have any questions, please contact our Billing Department at 866-718-5757, Option 2.

Thank you.

Attestation of Financial Hardship

I attest that I am experiencing a financial hardship and am unable to pay the balance due on my account, either in installments or in full at this time and for the foreseeable future. I am requesting that the balance on my account be considered for an adjustment based on hardship.

Date

dd-MMM-yyyy

Patient Name

First Name *Last Name*

Address

Street Address

Address Line 2

City

State/Region/Province

Postal / Zip Code

-Select-

Country

Phone

Responsible Party If Other Than Patient

First Name

Last Name

Signature of Patient or Responsible Party *

Clear

Review Save Submit