Leading the Way
in Intrathecal PainCare™

Patient Financial Assistance Form

AIS™ is required by law to collect health insurance deductibles and co-insurance payments for prescription medications from patients; however, we understand there may be circumstances that make it difficult for a patient to pay these financial obligations in full. If you find yourself in this situation, AIS may be able to help you.

AIS has a process for screening individual patient requests for discounts, delayed payment plans and debt forgiveness, which is based on the information provided in this two page form. Please complete the following to the best of your ability. AIS will keep all of your information confidential as explained in our privacy policy.

Patient Name: ______________________ Date of Birth: ______________________

Social Security Number: ______________________ Marital Status: ______________________

Address: ____

City: ______________________ State: ____________ Zip: ____________

Home Phone Number: ______________________ Work Phone Number: ______________________

Cellular Phone Number: ______________________ Email: ______________________

Insurance Carrier: ______________________ Citizen of The United States: Yes ______ No ______

Policy Holder Name: ______________________ Relationship: ______________________

Employer: ____

Employer's Address: ____

City: ______________________ State: ____________ Zip: ____________

Employer's Phone Number: ______________________ If unemployed, length of time: ______________________

Number of family members living in the patient's household and/or receiving financial assistance from the patient: ______________________

For each family member living in the household, please indicate his or her name and respective employer(s), along with each employer's address:

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Are you currently receiving any Medicaid Benefits? (check one)

- ☐ If YES, please provide your Medicaid I.D. # ________________ for verification and skip the sections labeled Monthly Income and Expenses.
- ☐ If NO, please complete all sections of this application.

Please do not forget to sign and date below.

Monthly Family Net Income and Sources:

$ ________________ Monthly Salary (Net)
$ ________________ Disability Benefits / Social Security Benefits / Worker's Compensation
$ ________________ Retirement Income (401K, Pension, etc.)
$ ________________ Public Assistance Benefits
$ ________________ Unemployment Benefits
$ ________________ Child Support and / or Alimony
$ ________________ Other (Please Describe) ________________
$ ________________ Total Family Income

Monthly Family Living Expenses:

$ ________________ Mortgage / Rent
$ ________________ Homeowners and Renters Insurance
$ ________________ Utilities (Power, Gas, Water, Cable, Internet, Phone, etc.)
$ ________________ Loans (Auto, Student, Home Equity, Credit Card Payments, etc.)
$ ________________ Auto Insurance
$ ________________ Auto Fuel and / or Maintenance
$ ________________ Groceries
$ ________________ Life Insurance
$ ________________ Health Insurance (Premium, Out of Pocket Expenses & Co-pay for Medical, Dental & Vision)
$ ________________ Taxes (Property, etc.)
$ ________________ Financial Assistance Provided to Other Family Members
$ ________________ Other (Please Describe) ________________
$ ________________ Total Family Expenses

I understand that the information provided in this form is complete and correct to the best of my knowledge. I give AIS™ permission to confirm that the information is accurate in order to determine financial need.

Signature: ________________________ **Date:** ________________
(Patient's Signature or Parent / Responsible Party, if Applicable)

FOR OFFICE USE ONLY Patient's MRN #: ________________

This AIS Patient Financial Assistance Form was received on

________________ by ________________
DATE PRINT NAME

Status: ☐ Request Approved ☐ Request Denied

____
SIGNATURE DATE

Please return this form via mail, fax or email:

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Ridgeland, MS 39157

Phone: 877.443.4006
Fax: 888.298.0092
Email: financialassistance@aispaincare.com