Dear Patient/Guardian,

Thank you for your interest in the Drugscan Patient Financial Assistance Program.

In order to obtain financial relief, you must complete the attached Patient Assistance Program Eligibility Application form and return it with one or more of the documents listed below, via mail, fax or email listed at bottom of page.

- A copy of last year's W2 form
- A copy of last year's income tax return
- A copy of your most recent pay stub(s)
- A proof source indicating that you are eligible for local, state or federal assistance programs

Missing information or documentation could result in your application being delayed or denied.

Once we have received your completed application and documentation, we will determine if you meet the established criteria. Please allow approximately two weeks for your application to be processed. Do not make any payments until you receive notification regarding the status of your request. Applying for acceptance into our Patient Financial Assistance Program does not guarantee reduced charges.

If you have any additional questions or concerns, please do not hesitate to contact us. Thank you for using Drugscan. We look forward to serving you in the future.

Sincerely,

Patient Billing Customer Service

PO Box 347, Horsham, PA 19044 | Phone 844-345-1821 | Fax 215-674-4157 | patient.billing@drugscan.com

DRUGSCAN
CALL: 844-345-1821
WEBSITE: DRUGSCAN.COM
EMAIL: patient.billing@drugscan.com

PATIENT ASSISTANCE PROGRAM
ELIGIBILITY APPLICATION

This form is used to request exemption from paying fees or a waiver of the fee or portion of the fee associated with services performed by DRUGSCAN on the basis of financial hardship.

This Eligibility Application MUST be accompanied by one or more of the following documents:

- **A copy of last year's W2 form**
- **A copy of last year's income tax return**
- **A copy of your most recent pay stub(s)**
- **A proof source indicating that you are eligible for local, state or federal assistance programs**

The information requested allows us to comply with all applicable guidelines and restrictions regarding our Patient Assistance Program.

Name: _____ Date of Birth: _____
Street Address: _____
City: _____State: _____ Zip Code: _____
Daytime Number: _____ Email Address: _____
Accession Number (If Applicable) _____
***** Annual Household Income_____**
***** Persons in Household_____**
Name of Employer and Occupation:
_____
Work Address: _____
_____ _____
*** **Patient Signature** *** **Date**

I hereby acknowledge that the information given herein is true and correct. I authorize DRUGSCAN to verify any information contained in this document for the sole purpose of assessing financial need. This form is valid for up to 6 months from the date of issuance at which time a new form is required. If your financial situation changes prior to 6 months, please contact DRUGSCAN Customer Service at the number listed below.

****** - Required to qualify for Financial Assistance***