Patient Financial Hardship Application

Patient Name:
Telephone Number:
Patient Date of Birth:
Address:
City, State, Zip:
Labcorp Invoice Number(s) related to this application:

1. Does the patient referenced above have medical insurance coverage? ☐ Yes ☐ No

If "Yes;' please list responsible party information: (Please include a copy of insurance card.)

Insurance Carrier Name:
Insurance Carrier Address:
Insurance Carrier Phone Number:
Policyholder Name:
ID#:

2. Total annual gross household income*: $

**This should be income at this time to account for a layoff or other type of job change. Total household income includes the following for all members of your household: Gross Salary, Unemployment Compensation, Disability and Workers Compensation, Social Security and/or Supplemental (SSI) Benefits, Public Assistance (TANF, SNAP, etc.}, Other income.*

3. Number of family members in household supported by above income:

4. (Optional) Please advise of any extenuating circumstances that you would like us to consider. This would include issues related to COVID-19.

I hereby acknowledge the above information is true and correct. I understand that I will be notified by Labcorp (1) If I do not qualify for assistance, or (2) If I do qualify, in which case Labcorp will provide details on any available discount. I authorize Labcorp to verify the information I provided for the sole purpose of assessing financial need, including by seeking supporting documentation. I understand that if I do not qualify for assistance, Labcorp will bill me at the applicable rate. I hereby acknowledge that I am neither related to, nor employed by, the physician who ordered the testing.

Responsible Party Name:
Responsible Party Signature: **Date:**

Please submit completed application via:

Email: financialhardship@Labcorp.com **OR** **Mail:** **Labcorp of America, Attention: FH**
PO Box 1558
Burlington, NC 27216-1558

For Internal Use Only:
Billing Customer Service Representative Name: **Date:**