Virtua's Reduced Fee Assistance Program

At Virtua, our mission is to provide every patient with an outstanding experience, regardless of his or her ability to pay for services. For patients who do not have health insurance and are not eligible for state or federal assistance such as Medicaid, Virtua may be able to help. Based on your income and medical needs, you may qualify for financial relief through Virtua's Reduced Fee Assistance Program.

You may be eligible for a significant reduction to your hospital bill if:

- You have no insurance coverage.
- You are not eligible for Medicaid.
- You are not eligible for a 100 percent adjustment under the State of New Jersey Charity Care program. • You are not eligible for reimbursement from any third parties such as lawsuits, employers, schools, or churches.
- The gross annual income for your household is less than $200,452

If you meet **all** of the above criteria, please fill out the application on the back of this form and attach a copy of your latest paycheck stub or income source. Please note that financial relief applies to hospital services only. You may receive separate bills from other providers, such as physicians. Completed forms should be sent to:

Virtua Patient Accounting
2000 Crawford Place, Suite 100
Mount Laurel, NJ 08054 ATTN:
Reduced Fee Assistance Program

What if I have questions?

Representatives are available toll-free at 1-833-335-4010.

Application for Virtua's Reduced Fee Assistance Program

PATIENT INFORMATION

Last Name First Name MI

Street Address

City State Zip Code

Date of Birth Social Security Number Gender(M/F)

RESPONSIBLE PARTY

Last Name First Name MI

Street Address

City State Zip Code

Date of Birth Social Security Number Gender(M/F)

INSURANCE INFORMATION

	Yes	No
1-) Are you covered under any health insurance, including foreign coverage?	☐	☐
2-) Was treatment due to a work-related injury or motor vehicle accident?	☐	☐
3-) Do you have a lawsuit or claim pending associated with this injury or illness?	☐	☐
4-) Do you have an application pending for Medicaid or Charity Care?	☐	☐

INCOME INFORMATION

Please indicate if earnings are weekly (W), monthly (M) or annual (A).

For Facility Use Only

Total Verified annual income: _____ Approved by: _____
Patient Account #

EARNED INCOME

Name of Family Member	Name and address of employer	Gross Earnings	How often
1-)			W M A
2-)			W M A
3-)			W M A

OTHER INCOME

Source	Amount	How often
Social Security		W M A
Retirement Benefits		W M A
Pensions		W M A

Source	Amount	How often
Alimony		W M A
Child Support		W M A
Other Income		W M A

Please attach copies of the latest paycheck stub or other income source and mail completed form to:
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Mount Laurel, NJ 08054
ATTN: Reduced Fee Assistance Program

Applications MUST be submitted with paycheck stubs or other income documentation. Applications without this information cannot be processed and will be returned.

I certify that the above information is true and accurate to the best of my knowledge. If any information I have given proves to be untrue, Virtua may, at its own discretion, withdraw this special discount and the full amount of the bill will become due and payable.

_____ _____ _____
Applicants Name (Please print) Applicants Signature Date