#111 attachment Appendix D – Notification

Financial Assistance Determination Notice

Date: _____

Patient Name: _____

Account #: _____

- **Approved** – Your request for Financial Assistance has been approved. Your qualifying discount is __ %.*
    - Discount is approved as one-time only.
    - This application and any discount given is applicable to only the account and date of service specified. Future accounts are subject to routine billing.

- **Denied** – Your application for Financial Assistance has been denied for the following reason(s): _____
_____
_____
_____

- **Pending** – Your application is pending. To complete your Financial Assistance application we are still in need of the following information: _____
_____
_____
_____

If you were denied Financial Assistance please contact the Business Office at (484)526-3117 for payment plan options.

Signed: _____

01/2024