APPENDIX B: WHS Financial Assistance Policy

Financial Assistance Application Appeal

Today's Date: __________ **Patient Full Name:**____

Last First Middle

Date of Birth: _____________ Is patient a minor? Yes or No

Phone Number: (_____) ______________________

Area Code Number

Account # (s):____

Address:____

Street Address Apartment/Unit #

____

City State Zip Code

___ Check here if patient is his/her own guarantor. Otherwise, add Guarantor information

Guarantor Name: ____

Last, First Middle

Phone Number: (_____) _______________________________

Area Code Number

Relationship to Patient: ______________ **Date of Birth**: ____________________________

Address:____

Street Address Apartment/Unit #

____

City State Zip Code

1. Please explain the reason(s) you are appealing and attach any documentation you believe supports your appeal. **Mail or deliver your appeal to: Wellmont Single Billing Office, 105 W. Stone Drive, Suite 6A, Kingsport, TN 37660**