Revere Health
Financial Consideration Request

Date of Service:_____ **Physician**:_____ **Patient Account Number**:_____

Patient Name:_____ **Date of Birth**: _____

Address: _____

Insurance:_____ **Policy Holder**:_____

Number of Dependents:_____ **Monthly Household Income**: $_____

Monthly Expenses: $_____

Please indicate the reasons why you are requesting assistance with charges:

_____

_____

_____

_____

_____

Signature: _____ **Date**: _____

----------**Clinic Use Only**----------

***If ongoing treatment is required, please indicate if the patient is to be referred to Health Clinics of Utah.**

YES **NO** **Referral Date**:_____ **By**:_____

(Please Indicate which option below)

Reduce balance in full? YES NO Reduce Balance by Amount:_____ Reduce by %:_____

Physician Signature: _____ Date: _____

Comments: _____

_____

I certify that information listed above is true and correct to the best of my knowledge. Giving false information will nullify this agreement and payment will be due in full.

The Financial Consideration Request Form must be filled out for each visit. The application must be signed by the patient and returned directly to the rendering physician's office for the physician(s) signature. All questions, including the approval or denial of the financial consideration request, must be made directly to the Physician's office where the services were rendered.

Please return the form to charityapplication@reverehealth.com or to Patient Services 1055 N 500 W Suite 102, Provo UT 84604
Date of Adjustment _____ Amount Adjusted _____