Byram Healthcare

Financial Hardship Program

2014

Dear Byram Customer:

We are pleased to offer here at Byram our Internal Financial Hardship program. We here at Byram understand that the costs associated with managing a long term condition can be overwhelming, particularly in times of economic downturn and high unemployment rates. While we feel that every person should be personally invested in his or her healthcare decisions and spending, covering those costs can create a genuine hardship for many patients.

For this reason, Byram has implemented a Financial Hardship Assistance program to assist with copay expenses for those customers in greatest need. Please find the necessary criteria requirements needed below to qualify for this program.

Please fill out the enclosed application form. If there are sections that do not apply due to your marital status or employment status, just circle the appropriate answer and skip the section.

Once completed, **please attach the appropriate documentation.** In order to conform to both insurance and Medicare/Medicaid audit requirements, we must have supporting documentation on file. **Please be assured that any and all information provided by you will be held in the strictest confidence, and Byram will never share any information about you with any 3rd party, ever.**

The more information you can supply, the more quickly we can process your application. Last year's tax return or the Social Security Benefit Award Letter is the most important information you/spouse can provide that will allow us to make a fair decision and maximize you/spouse chances of being approved. If you or your spouse is working, a W2 is vital as well.

If you are retired, please include any recent social security, assets, or pension statements. Once all supporting documentation is received a coordinator will then process and review and a decision will be rendered within 4-8 weeks.

Application will not be processed without supporting documentation.

Reasons for denial:

- Your level of income/assets exceeds the defined criteria for approval.
- You have no income or assets note: (If filed as a dependent, your legal guardian has to assume financial responsibility and complete the application)
- Insufficient Financial documentation (No proof of Income or Medical Expenses)
- Non-Insurance-You must have a primary Insurance to apply for program which covers copays/co-insurance

Note: If you are denied you can reapply for approval after 6months. Also if denied you can appeal up to two times for approval. Excluded products/services: Byram Hardship program does not apply to any non-covered items. Assistance applies to the allowed covered items not including any overages in which you are entitled to pay for.

It also excludes Byram Insulin pump supplies, Erectile Dysfunction Supplies, and Oral Enteral Programs.

If you have any questions, please don't hesitate to contact our Billing Liaison department at the number below. Just tell the operator you have a question about the hardship program, and they'll make sure you get connected to someone who can answer all your questions.

Byram Healthcare

1-877-902-9726 Ext. 33967

The PSF program in any way constitutes a waiver of routine coinsurance, deductible or copayment and the aid is granted only when the need has been demonstrated sufficient. The program is administered Byram PSF without considering the applicant's age, sex, race, religion, sexual orientation or any other attributes other than financial need. **Byram Healthcare reserves the right to modify or discontinue the provisions of the program at any time.** *Please be aware that Byram's hardship program complies with all state and federal regulations and in some cases may not be available to you. Certain insurance companies do not allow hardship provisions. Any patients covered by a plan that utilizes means testing (Medicaid, for example) are ineligible for assistance. Hardship assistance does not apply to non-covered items. Hardship cannot be applied to commercial deductibles or Medicaid spenddowns.* ***Assistance is limited to a maximum of 12 months or less and it is the patient's responsibility to re-apply annually.***

Financial Hardship Assistance Application

2014

Patient Name: _____ (Last / First / MI)

Address: _____ (Street / Apt.)

_____ (City / State / ZIP)

Primary Phone: _____

Alt. Phone: _____

Fax: _____

E-mail: _____

Byram Account No.: _____

Guarantor (if different): _____ (Last / First)

Address: _____ (Street / Apt.)

_____ (City / State / ZIP)

Phone: _____

E-mail: _____

Household

Number of household members		Dependant?
Age 0-21		YES NO
Age 22-64		YES NO
Age 65+		YES NO
TOTAL		

Eligible Medical Expenses

Hlth Insurance Premium/Mo.:	
Individual Deduct. Amt :	
Family Deduct. Amt:	
Non-covered expenses paid:	
Out of Pocket Limit:	
Out of Pocket Actual	
Education expense per yr.	

Other Coverage

Have you applied for Medicaid?	Y	N
If yes, approved or denied?		
Recipient ID Number		
Have you contacted any charitable assistance organizations?	Y	N

Income & Assets

Applicant — Employed / Unemployed / Disabled / Retired (Please circle one)

If employed:

Employer: _____

Address (City/State): _____

Years at Employer: _____ (City / State)

Medical/Rx Insurance through employer? Y N

Annual Income: _____

401K/IRA Balance: _____

Other Investments: _____

Checking Balance _____

Savings Balance: _____

Spouse (if applicable) — Employed / Unemployed / Disabled / Retired (Please circle one)

If employed:

Employer: _____

Address (City/State): _____

Years at Employer: _____ (City / State)

Medical/Rx Insurance through employer? Y N

Annual Income: _____

401K/IRA Balance: _____

Other Investments: _____

Checking Balance _____

Savings Balance: _____

I understand that the information provided herein will be used to determine my eligibility for hardship assistance from Byram Healthcare and shall not be sold, distributed, or used in any other way or for any other purpose. I hereby attest that all information provided here is, to the best of my knowledge, accurate and complete and that any misrepresentation will result in the denial of assistance benefits and the recovery of any amounts previously adjusted. *Further, I understand that any assistance is limited to a maximum 12 month period and must be annually renewed, and that any change in financial circumstances must be immediately reported to Byram Healthcare.* I understand that Byram Healthcare retains the right to modify or discontinue this program at any time without prior notification.

APPLICATION WILL NOT BE PROCESSED WITHOUT SUPPORTING DOCUMENTATION.

X _____

Signature Date