RestorixHealth®
Excellence in Wound Care

Toll Free: 888.700.8029

Hardship Waiver Request

You've recently received medical supplies from RestorixHealth. Due to federal and state laws, and because of our agreements with the many health insurance companies, we are required to collect co-payments and/or deductibles from all customers. If you have secondary or other insurance coverage, they may pay for all or part of the remaining balance.

You should have received an invoice and/or statement from us detailing the amount you owe after we've been paid by your insurance carrier(s). You've indicated that you do not have secondary coverage, or that you are otherwise financially unable to pay your bill.

If you demonstrate a sufficient financial hardship, our company may be able to waive the balance due. To be considered for a waiver, please fill out the form below. We may contact you or your caregiver for more information, if necessary. Completion of this application does not guarantee that your request will be granted.

If you need assistance completing this form, please contact: **billing@woundsupplies.com**.

PATIENT NAME

RESPONSIBLE PARTY (if any)

RELATIONSHIP OF RESPONSIBLE PARTY

STREET ADDRESS

CITY STATE ZIP

PHONE

EMPLOYMENT STATUS ☐ Employed ☐ Unemployed ☐ Retired

Due to my current financial hardship, I am unable to pay the co-payment, deductible or other medical charges for which I've been billed by RestorixHealth. My financial hardship includes the following (check all that are applicable):

☐ I am a resident of a nursing facility and have no income other than social security income, which is paid to the facility. I do not have other assets that would allow me to pay the patient share amount. I authorize RestorixHealth to verify this with the nursing facility where I reside.

☐ My annual household income is less than 200% of the federal poverty guidelines (please see below for current guidelines). I do not have other assets that would allow me to pay the patient share amount. Documentation verifying this is included. Documentation can include, for example, W2 income withholding statements, tax returns, paycheck stubs, forms previously completed to obtain Medicaid, unemployment assistance or other state-funded assistance programs. If you have questions about acceptable documentation, please contact RestorixHealth at the number above.

Poverty guidelines are updated annually. 2023 information obtained from FederalRegister.gov. If you live in Alaska or Hawaii, please contact us for current applicable rates in those states.

☐ I am otherwise unable to pay the medical bill presented for the following reasons. Please include additional pages or documentation as necessary to allow us to verify any information set forth below:

Persons in family/household	200% of 2023 Guidelines
1	$29,160
2	$39,440
3	$49,720
4	$60,000
5	$70,280
6	$80,560
7	$90,840
8	$101,120

If family size is over 8, please add $10,280 for each additional person.

I hereby certify that no other source, including a parent, spouse or other person or program is legally responsible for my bills. I certify that the information on this form and supporting documentation is true, complete and correct. I authorize amt to verify any information contained in this document for the sole purpose of assessing my financial need and ability to pay my medical bills.

NAME

RELATIONSHIP TO PATIENT
(If responsible party)

DATE SIGNATURE

FOR RESTORIXHEALTH USE ONLY

Reviewed By Date

☐ Approved ☐ Denied

Reason

HARDSHIP WAIVERS ARE VALID FOR ONE YEAR FROM DATE OF APPROVAL. PATIENT MUST REQUEST AND RECERTIFY FINANCIAL HARDSHIP CONDITIONS FOLLOWING ONE YEAR ANNIVERSARY.