

**FINANCIAL ASSISTANCE APPLICATION**

Thank you for inquiring about PCG Molecular’s Financial Assistance Program.

In order to qualify for financial assistance, please complete the application in its entirety. Return the completed application along with copies of all required documents to:

**PCG Molecular, LLC**

Attn: Director, Revenue Cycle

1230 Bald Ridge Marina Rd

Cumming, GA 30041

Upon receipt, PCG Molecular will review your application and all required documentation to determine if the Financial Assistance criterion has been met. If any documentation or information on the application is missing, PCG Molecular will not be able to process your application. Only applicants who meet the requirements will qualify for a reduction in charges.

Please allow 2-3 weeks for processing.

If you have any questions, please call our Patient Billing office at (404) 301-4460

Sincerely,

PCG Molecular Patient Billing Department

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# FINANCIAL ASSISTANCE APPLICATION

***Please print clearly. Be sure to complete all requested information.***

Patient’s Name: Date of Birth:

 Last First MI

Address:

 Number and Street City State Zip

Telephone No. (\_\_\_) Family Size/Dependents in Home: \_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: Employer Telephone (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address:

 Number and Street City State Zip

|  |  |  |
| --- | --- | --- |
|  | **Last 3 Months**  | **Last 12 Months**  |
| Income (includes Wages, Earnings, Unemployment, Public Assistance, Social Security, Workers’ Compensation, Alimony, Child Support, Pensions, Income from Dividends, etc.)   |   |   |
| Medical Expenses     |   |       |

\*Please submit documentation for the income you entered above. Examples of documentation might include pay stub, tax return, letter from employer, W-2, Form 1040, recent medical bills, etc.

 This Application may be submitted to PCG Molecular at any time during the billing and collection process.

 I REQUEST THAT PCG MOLECULAR DETERMINE MY ELIGIBILITY FOR CHARITY CARE OR FINANCIAL

ASSISTANCE. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO

VERIFICATION, AND I AUTHORIZE PCG MOLECULAR TO VERIFY ANY INFORMATION IN THIS

APPLICATION. I UNDERSTAND THAT IF INFORMATION WHICH I SUBMIT IS FALSE, IT WILL RESULT IN A DENIAL OF FINANCIAL ASSISTANCE. I AFFIRM THAT THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

****Date Signature Account #