Bay Imaging Consultants Medical Group
2125 Oak Grove Rd, Suite 200
Walnut Creek CA 94598
925-296-7156 Main
925-296-7174 Fax

To Whom It May Concern.

Please find attached a financial assistance application. Please fill out in the entirety and return with your proof of income for review and approval for a financial assistance discount of up to 75%.

Sincerely,

Billing Follow-Department

Please note: Proof of income is required to be reviewed for approval of an assistance discount. The acceptable documentation is listed below: **Please provide at least two of the below for consideration of financial assistance discounts.**

- Recent check stubs
- Recent Tax return
- Unemployment stubs
- Disability letter showing income
- Social Security statement showing annual income

Once all information is attached to the application, please mail to the address above or fax to the attention of: Billing

Thank you.

BAY IMAGING CONSULTANTS MEDICAL GROUP

Tax ID 94-2965646
P.O. Box 31455
Walnut Creek, CA 94598

Main 925-296-7156
Fax 925-296-7174

Charity Assistance Program – **PLEASE COMPLETE AND MAIL TO THE ADDRESS ABOVE**

The Patient Assistance Program is a program offered by Bay Imaging Consultants Medical Group for the purpose of offering financial assistance for medical bills/services provided by our physicians.

All requested documents must be submitted in order for the application to be completed, and to be considered for approval up to 75% discount. Bay Imaging Consultants Medical Group does not offer 100% discounts for charity.

Section I – General Information
PLEASE PRINT ALL RESPONSES

Patient Name _____ _____
(First Name) (Last Name)

Address _____ _____
(Street Number and Street Name) (Apt. #)

_____ _____ _____
(City) (State) (Zip)

Date of Birth: ____/____/____ Social Security Number: ____-____-____

Contact Number: (___)_____Cell Phone Number: (___)_____

Section II – EMPLOYMENT**

1. Are you currently employed, or were you employed at the time you had your medical services?
   a. Yes _____
   b. No _____
2. Are you married:
   a. Yes _____
   b. No _____
3. How many dependents do you have? _____

Section III – Proof of Income for everyone in your household**

Please provide the following information. Failure to provide all of the following information could result in a denial of your application.

- Tax Return for the most current year
- Current W-2's
- Current pay stubs
- Unemployment pay stub

Note: If you do not have current income please provide a statement from the social security office as proof of no income.

Section IV – FOR OFFICE USE ONLY

Patient is denied for charity/hardship for the following reason: _____