DOMINION DIAGNOSTICS

# **REDUCED RATE** REQUEST FORM

Please fill out this form to request a Reduced Rate for services provided by Dominion Diagnostics

PATIENT INFORMATION

ACCOUNT NUMBER _____

PATIENT NAME _____

DATE OF BIRTH _____

ADDRESS ON FILE* _____

CITY/STATE/ZIP _____

PHONE _____

*IF NECESSARY, PLEASE PROVIDE AN UPDATED ADDRESS AND/OR PHONE NUMBER BELOW.

NEW ADDRESS _____

NEW CITY/STATE/ZIP _____

NEW PHONE _____

HOUSEHOLD INCOME INFORMATION**

CURRENT GROSS OR ADJUSTED GROSS ANNUAL INCOME (SELF) $ _____

CURRENT GROSS OR ADJUSTED GROSS ANNUAL INCOME (SPOUSE/PARTNER) $ _____

COMBINED TOTAL GROSS OR ADJUSTED GROSS ANNUAL INCOME (FAMILY) $ _____

TOTAL PERSONS IN HOUSEHOLD (INCLUDING SELF) _____

PATIENT ACKNOWLEDGMENT & SIGNATURE

I hereby acknowledge the above information is true and accurate. I authorize Dominion Diagnostics to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation for the above request (e.g., W-2, paystub). I understand that if I do not qualify for a reduced rate, I will be notified by Dominion Diagnostics and responsible for my full bill. I hereby acknowledge that I am neither related to, nor employed by, the provider who ordered the testing.

**SIGN HERE** _____ _____

Patient Signature Date

INTERNAL USE ONLY

**Statement:** _____

**Reviewed by:** _____

☐ APPROVED ☐ DENIED Reason for Denial: _____

## SUBMIT FORMS TO:

Fax **(401) 667-0331 (HIPAA Secure)**

Mail **Dominion Diagnostics, ATTN: Billing**
**211 Circuit Drive**
**North Kingstown, Rhode Island 02852**

FOR INQUIRIES, PLEASE E-MAIL:
**patientinfo@dominiondiagnostics.com**

QUESTIONS? Please call Dominion Diagnostics Billing Department at 1-800-511-8427, Prompt 4.

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