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**
PO BOX 638889
Cincinnati, Ohio 45263-8889

For inquiries, please email:
patientinfo@dominiondiagnostics.com

QUESTIONS? Please call Dominion Diagnostics Billing Department at 800.511.8427, Option 4.