ASANTE®

Financial Assistance Appeal Form

Date:

First and Last Name:

Current Address:

Date of Birth:

Medical Record Number or Patient Identifier Number from the Notice:

Reason For Denial

☐ Financial Assistance Application was incomplete or missing documentation.

☐ Patient was determined to not be financially eligible to receive financial assistance, in full or in part.

☐ Financial Assistance Application was corrected but patient was determined not to be financially eligible.

Statement of Appeal

Please explain the basis for your appeal below; if additional space is needed, you may attach additional pages to this form.

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Additional Documentation

☐ Check here if additional or corrected documentation is attached.

Please list the attached documents below

Request for Meeting to Determine Resolution

☐ Check here if you would like to request a meeting with the designee of the Chief Financial Officer to make a final determination of your appeal.

- ☐ I prefer an in-person meeting
- ☐ I prefer a video conference
- ☐ I do not have a preference

☐ Check here if you do not want to request a meeting.

If you have requested a meeting, a representative from Asante will reach out to you to schedule a meeting. If you have not requested a meeting, Asante will review your appeal and provide you with a written decision.

Submission

This appeal must be submitted no later than 240 days from the date that you received a notice that your financial assistance application was denied.

An appeal must be submitted using one of the methods below:

Mail:

Asante Patient Financial Services

P.O. Box 4749

Medford, Oregon 97501-0227

Fax:

Asante Patient Financial Services

541-789-5522

Email:

Patient.credit@asante.org

MyChart:

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Upload via your MyChart account.

We will respond within 30 days of the date of receipt or final appeals meeting, whichever is later.

Signature Relationship Date

Note: Asante may request an authorization from the patient if the person signing this form is anyone other than the patient.