Avera Marshall Regional Medical Center
300 S. Bruce St.
Marshall, MN 56258
507-532-9661

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR UNINSURED DISCOUNT

I Request Avera Marshall Regional Medical Center to make a determination of my eligibility for an Uninsured Discount. I understand that the information, which is submitted concerning annual income, is subject to verification by Avera Marshall. I understand that if the information submitted is determined to be false it will result in a denial of the Uninsured Discount.

If you qualify for the discount, this document will be valid for a one year period. If you are denied the discount you may reapply within one year if you have a significant change in status. If there is not a significant change, then reapplication can be made in one year.

1. **Patient Name:** _____

   Address: _____

   Telephone: _____

2. Family size: (List everyone living in household)

Name	Age	Relationship

3. Please provide a copy of your most recently completed Federal Tax Return.

   If a tax return is not available please talk to your credit/collections representative or your patient account representative before returning this form.

4. Total income from everyone living in household: _____
5. I affirm that the above is true and correct to the best of my knowledge and give Avera Marshall permission to verify any/all statements.

_____ _____

Patient/Responsible Party Signature Date

OFFICE USE ONLY

Approved for Uninsured Discount: Amount _____

Signature: _____ Date: _____

NOT approved for Uninsured Discount: Comments/reason: _____

Signature: _____ Date: _____