

## Financial Assistance Application

*If you need help to complete this form, please ask to speak with one of our Customer Service Representatives or call (505) 291-2300.*

Name of Facility NMSCO Patient Name \_\_\_\_\_ Account Number \_\_\_\_\_

### Instructions for completing this form:

**This completed form should be attached to the required documentation and returned to NMSCO to be processed.**

- Prior year's tax return(s)
- Minimum of two most recent pay stubs

Responsible Party Name \_\_\_\_\_ Last 4 digits of Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Other Responsible Party Name \_\_\_\_\_ Last 4 digits of Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Cell Phone \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Gross monthly/annual income \$ \_\_\_\_\_

### Additional Household Members

Name	DOB	Relationship	Name	DOB	Relationship

**Persons who apply for financial assistance are required to first explore other sources of funding. Please indicate which sources you have applied for and the reasons you are not eligible for this assistance.**

- Group health insurance \_\_\_\_\_  
Does your employer offer group health insurance yes/no
- Medicaid- if denied, please attach a copy of the Medicaid denial
- Other state or county assistance (Sole Community, Indigent)
- Other third-party programs (homeowners, auto etc.)
- Cobra Coverage

**Signature required on back of form**



**NEW MEXICO SURGERY CENTER  
ORTHOPAEDICS**

A PRESBYTERIAN PARTNERSHIP

At Presbyterian Kaseman Hospital

Describe inability to pay account balance: (additional documentation may be required)

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If you do not have the required documentation listed, please inquire as we may be able to accept alternative documentation to satisfy this requirement. Patients who fail to follow through in the application process, or who refuse to apply for outside programs and who potentially may have qualified, may be denied financial assistance.

I hereby state that the information given herein is true and correct. I authorize any required verification, including credit bureau report. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance does not pertain to other healthcare providers.

Please return completed application and required documentation to or you can fax it to (505) 213-0339:

**New Mexico Surgery Center Orthopaedics**

Attention: Business Office  
8300 Constitution Ave NE  
Albuquerque, NM 87110-7613

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*NMSCO is committed to protecting the confidentiality of its patients. Any information provided by individuals to NMSCO through the financial assistance application process will remain confidential, will only be used by NMSCO for its internal purposes, and will not be released to any third parties outside of the NMSCO without the express consent of the individual.*

**For Internal Use Only:**

<i>Account Number</i>	<i>Facility</i>	<i>Amount</i>	<i>Account Number</i>	<i>Facility</i>	<i>Amount</i>

**Approved** \_\_\_\_\_ **Date** \_\_\_\_\_

- 50% assistance
- 75% assistance
- 100% assistance

**Denied** \_\_\_\_\_ **Date** \_\_\_\_\_

- Income greater than 400% of the federal poverty level
- Documentation not received