NorthShore
MEDICAL GROUP

Patient Assistance Plan Application

The Patient Assistance Program is available to patients based upon family income and size. Please complete the following information to determine if you and other members of your family are eligible for a discount.

The discount will apply to medical services received at this clinic. There are some non-covered services such as elective procedures/surgeries, and services which are purchased from providers outside of NorthShore Medical Group (reference laboratory testing, prescriptions, hospital services, or x-ray interpretation by a consulting radiologist for example).

In the hope that your financial situation improves, discounts apply for one year from application, or whenever you become insured (whichever comes first). Please inquire at the Business Office if you have any questions or would like assistance in completing the application.

Patient Name: _____ Date of Birth: _____

Phone Number_____

Names	**Dates of Birth**
Spouse:	
Dependent:	
Dependent:	
Dependent:	
Dependent:	

Revised: 9/16/2020

Please provide copies of the following:

Verification Checklist	**Type & Number**	**Date Received**
1. Photo Identification		
2. Prior Year Tax Return or Recent Pay Stubs		
3. Medicaid ☐ Not eligible to apply ☐ Evidence of Rejection		

I certify that the family size and income information shown above is correct and understand updated verification will be required annually to maintain discount status.

_____ _____

Name (please print) Signature & Date

NSMG Use

Date Approved: _____

Date Expires: _____