

DECLARATION OF HARDSHIP

This statement will affirm that I, _____, Social Security number, _____, am unable to pay for the services which have been prescribed and deemed medically necessary by my physician _____.

The services that have been prescribed include:

on a prescription dated _____. As I only have _____ healthcare insurance coverage and I am unable to afford a supplemental policy due to my limited income. I understand that this statement gives my healthcare provider the legal right to waive my responsibility for payment amounts not reimbursed by my insurance.

Signature of Beneficiary _____ Date _____
(Full name typed) _____

Signature of Witness _____ Date _____
(Full name typed) _____

Signature of Witness _____ Date _____
(Full name typed) _____

Signature of Provider _____ Date _____
(Full name and title typed) _____