N O R T H E R N A R I Z O N A H E A L T H C A R E

Northern Arizona Healthcare – Flagstaff
1200 N. Beaver Street
Attn: CBO - Debbie
Flagstaff, AZ 86001
928-773-2025
NAHealth.com

Northern Arizona Healthcare – Cottonwood
269 S. Candy Lane
Attn: Registration
Cottonwood, AZ 86326
928-773-2025
NAHealth.com

FINANCIAL ASSISTANCE

PLEASE RETURN WITH 30 DAYS

Northern Arizona Healthcare (NAH) is dedicated to providing exceptional quality care to every patient. As part of our commitment, we strive to assist our patients with financial obligations associated with their medical care. In order to help us determine if you qualify for a financial discount, we have enclosed an application for our Care Assistance Program.

Once we review your application, you may be asked to apply for AHCCCS. This request is based on the income level listed on your application. If you have already applied for AHCCCS and have a current Denial Letter, please include a copy when returning this application. If you are in the process of applying for AHCCCS or you have already been approved for coverage, please contact our office.

AHCCCS WEBSITE: https://www.azahcccs.gov/

Additional Circumstances that may impose financial hardship: Court Ordered Bankruptcy, Disability, Extended Illness, and Death. Catastrophic eligibility as determined by NAH Guidelines.

If you do not wish to complete this application, it is imperative you contact our billing office to make suitable payment arrangements regarding your balance.

Questions related to your care assistance, including discount calculation or the amount generally billed for this type of service, can be found on line:
https: //nahealth.com/patient-rights-policies/financial-assistance

A decision will be determined within 15 business days of receipt of your application with all required documents. If you have questions, please call **928-773-2025.**

Mission
Improving health, healing people.

Vision
Always better care.
Every person, every time…**together.**

FINANCIAL ASSISTANCE APPLICATION

For your convenience, there are several ways to submit your completed application with required documentation.

MAIL or DELIVER:

Flagstaff Medical Center
Attn: CBO – Debbie
1200 N. Beaver Street
Flagstaff, AZ 86001

Deliver to Outpatient Services: Use left entrance to ED Dept.

Verde Valley Medical Center
Attn: Registration
269 S. Candy Lane
Cottonwood, AZ 86326

Deliver to Cashier/Registration: Main Entrance

EMAIL ADDRESS: careassistance@nahealth.com

FAX: 928-639-6411

NOTE: Not receiving all required information with your completed application may affect our ability to approve assistance in a timely manner.

Please return application with documentation within 30 days.

If you have any question, please call Debbie at **928 773 2025.**

Northern Arizona Healthcare
Financial Assistance Application

If you are currently under AHCCCS SLMB or QI1 plan, you DO NOT have to complete this application. If approved under AHCCCS, please contact our office and provide your AHCCCS information.

Patient Name:		Date of Birth:
Guarantor Name: (If applicable)	Date of Birth:	Relationship to Patient:
Mailing Address:		
City:	State:	Zip:
Phone No.	Social Security No.	

List all persons living in household		
Name	Relationship	Date of Birth

Monthly Gross Income:	SELF	SPOUSE	OTHER
Wages/Self-Employment			
Social Security			
Other: Pension/Retirement			

PLEASE SUBMIT ONE OF THE FOLLOWING DOCUMENTS SHOWING PROOF OF INCOME PER PERSON, IF APPLICABLE: (Original documents cannot be returned)

Pay Stubs (Last 3); Social Security Benefits Letter and/or Pension Statement; Most Current Tax Return; Bank, Money Market and/or Mutual Fund Statement (Statement should reflect last 3 pay periods)

NOTE: A DECISION WILL BE MADE WITHIN FIFTEEN (15) BUISNESS DAYS OF RECEIPT OF THIS APPLICATION WITH ALL REQUEST DOCUMENTS

DISCLAIMER: I understand the information I provide will be used only to determine financial responsibility for my charges at Northern Arizona Healthcare, which include hospital and physician services and will be kept confidential. I understand that if any information I have given is determined to be false, it may result in reversing the financial assistance approval and I will be liable for the full amount of all charges.

My signature authorizes NAH to verify all information provided on this form. I certify that the above information is true and accurate to the best of knowledge.

Signature: _____ Date: _____

MAIL OR DELIVER APPLICATION TO ONE OF THE FOLLOWING LOCATIONS:
NORTHERN ARIZONA HEALTHCARE, Attn: CBO – Debbie, 1200 N Beaver St., Flagstaff, AZ 86001
VERDE VALLEY MEDICAL CENTER, Attn: Registration, 269 S. Candy Lane, Cottonwood, AZ 86326