

Fernanont Address: City: ZiP: State: WR Phone: WR Phone:	Patient Name:		DOB:		Dai	ELLIIN	
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State. ZP: Employer Name: Employer Ph: Employer Name: Employer Address: No State of S	-	t.	0:1				
Employer Name:							
Employer Address: Have you applied for financial aid or completed this form in the last 90 days? Yes							
Have you applied for financial aid or completed this form in the last 90 days? Yes			Employer I	² h:			
Do you currently have any type of health insurance? yes No 3 Was your provider visit a result of an accident at work? yes No 4 Was your provider visit a result of an accident at work? yes No If you answered YES to ANY of the questions above, STOP. Contact the Business Office of the Baptist facility where services were received to discuss your account. For the following table, please list the patient and all family members living in the same household as the patient. Family members are persons related by birth, marriage, or dopotion. Include age of all family members. Then, is the amount and source of each persons income. Income includes gross (pre-tabled by thith, marriage, or dopotion. Include age of all family members. Then, is the amount and source of each persons income. Income includes gross (pre-table dby thith, marriage, or dopotion. Income includes gross (pre-table dby thith, marriage, or adoption. Income includes gross (pre-table dby thith is signed application. Family Member (Name) Relationship to Patient Age Source of Income or Last Three Months Pay Stubs Tax Return Total Family Members Pay Stubs Tax Return Total Family Members Total Family Members Total Income Tax tributor for the previous year Legal documents/Child Support (or SA/Retirement Income Tax tributor for the previous year Peddral & State Assistance Documents Pensons/Intributement statements (for SSA/Retirement deposits only) Please return this application and the requested information to the Business Office of the Baptist facility where services were received. Legal documents/Child Support (or SSA/Retirement deposits only) Please return this application and the requested information to the Business Office of the Baptist facility where services were received. Legal documents/Child Support (or SSA/Retirement deposits only) Please return this application and the requested information to the Business Office of the Baptist facility where services were received.				_			
Was your provider visit a result of an accident at work? yes No							
Was your provider visit a result of an auto accident?			☐ Yes	□No)		
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Total Family Member (Name) Relationship to Patient Relationship to Patient Total Family Members Total Family Members Nour application cannot be processed unless you provide one of the following documents to support geath source of income listed above. Pay stubs for the last three months Income include the relationship and the requested information to the Business Office of the Baptist facility where services were received. It certify that the information provided is true and accurate to the best of my knowledge. Bale of Service Date of Service Date of Service Date of Service	4 Was your provider visit a result of an auto accident?			□No	1		
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Relationship to Patient Relationship to Patient Age Source of Income or Employer Name Pay Stubs Tax Return Age Source of Income or Employer Name Pay Stubs Tax Return Total Family Members Total Income Your application cannot be processed unless you provide one of the following documents to support each source of income listed above. Pay stubs for the last three months Income Tax return for the previous year Federal & State Assistance Documents Pension/retirement statements (for S&A/Retiremen deposits only) Please return this application and the requested information to the Business Office of the Baptist facility where services were received. I certify that the information provided is true and accurate to the best of my knowledge. Place of Service Place of Service Physician Physician Date Date of Service						ncome calculation	s must be submitted
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FOR PROVIDER USE ONLY Account Number Date of Service	Signature of Patient, or Per	rson Authorized to Sign for Patient			Relationship to Pati	ent	
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	FOR PROVIDER USE ONLY	,					
BMHCC Provider	Account Number			Date of Ser	vice		
	BMHCC Provider						

NEA BAPTIST.

NEA Baptist Jonesboro Business Office 4800 East Johnson, Jonesboro, AR 72405 FAX #: 870-936-1062 Email Address: fap@bmhcc.org

FINANCIAL APPLICATION

▼ Patient Label ▼