

Ballad Financial Assistance Application Appeal

Today's Date: _____ Patient Full Name: _____
Last First Middle

Date of Birth: _____ Is patient a minor? Yes or No

Phone Number: (_____) _____
Area Code Number

Guarantor and/or Account # (s): _____

Address: _____
Street Address Apartment/Unit #

City State Zip Code

___ Check here if patient is his/her own guarantor. Otherwise, add Guarantor information

Guarantor Name: _____
Last, First Middle

Phone Number: (_____) _____
Area Code Number

Relationship to Patient: _____ Date of Birth: _____

Address: _____
Street Address Apartment/Unit #

City State Zip Code

1. Please explain the reason(s) you are appealing and attach any documentation you believe supports your appeal.

Mail or deliver your appeal to:

**Ballad Health
Single Billing Office
105 W. Stone Drive, Suite 6A
Kingsport, TN 37660**