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 your appeal to:

   Ballad Health Charity Department
   PO Box 2308
   Johnson City, TN 37605