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DECLARATION OF HARDSHIP

This statement will affirm that I, _____, 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_____.

I have only _____ insurance coverage and am unable to afford a supplement/secondary policy due to my limited income. I understand this 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 Printed) _____

Signature of Witness_____ Date:_____

(Full Name Printed)_____