UNINSURED PATIENT
Verification Form

PARADIGM

Name and Address of Facility/Practice/Provider Treating the Patient:

First and Last Name of Patient who is UNINSURED:

Patient DOB:

Patient Social Security Number:

Patient's Current Address:

Patient Current Phone Number:

VERIFICATION OF PATIENT'S UNINSURED STATUS

ITEM # 1 - Check the box below if the patient represents that he/she is completely uninsured and has no healthcare insurance benefits from any entity or person.

Agreed, Patient is TRULY UNINSURED ☐

ITEM # 2 - List the NAME of any previous source of healthcare insurance benefits available to the patient within the last six (6) months. If none, check the box for "NONE"

Check Box if "NONE: ☐

ITEM # 3 - Is the patient in the process of applying for healthcare benefits? **Yes** ☐ **No** ☐

PATIENT SIGNATURE (REQUIRED):

Date Signed by Patient:

Full Name of Person Assisting Patient with this Form (if applicable) (REQUIRED IF 3RD PARTY COMPLETED THE FORM):

Initials of 3rd Party (if applicable)

Check Appropriate Box *if* 3rd Party Helped Patient Prepare this form:

- ☐ Paradigm Employee
- ☐ Facility/Practice Employee
- ☐ Caregiver/Guardian on behalf of Patient

FOR INTERNAL USE ONLY:

COMMENTS/NOTES REGARDING ACCOUNT AND BILLING COMPLIANCE NOTES (as needed)

NAME OF PARADIGM LABS BILLING SUPERVISOR:

Initials:

DATE REVIEWED: