



PFFIN

Patient Name: _____ DOB: _____ Date: _____
Permanent Address: _____ City: _____ ZIP: _____
State: _____ Hm Phone: _____ Wk Phone: _____

Mailing Address if Different:

Address: _____ City: _____
State: _____ ZIP: _____
Employer Name: _____ Employer Ph: _____
Employer Address: _____

- 1 Have you applied for financial aid or completed this form in the last 90 days? ☐ Yes ☐ No
2 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 auto accident? ☐ 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 adoption. Include the relationship and age of all family members. Then, list the amount and source of each person's income. Income includes gross (pre-tax) wages, rental income, unemployment compensation, social security, retirement, disability benefits, public assistance, etc. Documentation supporting the income calculations must be submitted with this signed application.

Family Member (Name)	Relationship to Patient	Age	Source of Income or Employer Name	Last Three Months Pay Stubs	Income for 12 Months 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

W2 Form for the previous year

Legal documents/Child Support

Bank Statements

Income Tax return for the previous year

Federal & State Assistance Documents

Pension/retirement 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.

I certify that the information provided is true and accurate to the best of my knowledge.

Signature of Patient, or Person Authorized to Sign for Patient

Relationship to Patient

Date

Place of Service

Hospital or

Physician

FOR PROVIDER USE ONLY

Account Number

Date of Service

BMHCC Provider



Baptist Anderson Business Office

2124 14th Street, Meridian, MS 39301

Fax #: 601-553-6063

Email Address: PatientAccounts@andersonregional.org

FINANCIAL APPLICATION

▼ Patient Label ▼