Reduced Rate Request Form

Please fill out this form to request a Reduced Rate for services provided by Dominion Diagnostics

Patient Information

ACCOUNT NUMBER ____________________

PATIENT NAME ____________________

DATE OF BIRTH ____________________

ADDRESS ON FILE* ____________________

CITY/STATE/ZIP ____________________

PHONE ____________________

*if necessary, please provide an updated address and/or phone number below.

NEW ADDRESS ____________________

NEW CITY/STATE/ZIP ____________________

NEW PHONE ____________________

Household Income Information**

CURRENT GROSS OR ADJUSTED GROSS ANNUAL INCOME (SELF) $ ____________________

CURRENT GROSS OR ADJUSTED GROSS ANNUAL INCOME (SPOUSE/PARTNER) $ ____________________

COMBINED TOTAL GROSS OR ADJUSTED GROSS ANNUAL INCOME (FAMILY) $ ____________________

TOTAL PERSONS IN HOUSEHOLD (INCLUDING SELF) ____________________

Patient Acknowledgment & Signature

I hereby acknowledge the above information is true and accurate. I authorize Dominion Diagnostics to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation for the above request (e.g., W-2, paystub). I understand that if I do not qualify for a reduced rate, I will be notified by Dominion Diagnostics and responsible for my full bill. I hereby acknowledge that I am neither related to, nor employed by, the provider who ordered the testing.

SIGN HERE ____________________ ____________________

Patient Signature Date

INTERNAL USE ONLY

Statement: ____________________

Reviewed by: ____________________

☐ APPROVED ☐ DENIED Reason for Denial: ____________________

Submit Forms To:

Fax **401.667.0331 (HIPAA Secure)**

Mail **Dominion Diagnostics, ATTN: Billing**
PO BOX 638889
Cincinnati, Ohio 45263-8889

For inquiries, please email:
patientinfo@dominiondiagnostics.com

QUESTIONS? Please call Dominion Diagnostics Billing Department at 800.511.8427, Option 4.