



www.smalaboratory.com

Toll Free Phone: **1-877-697-6252**

Toll Free Fax: **1-888-322-9524**

Phone: **(215) 322-6590**

Fax: **(215) 322-9524**

940 Pennsylvania Boulevard, Suite E, Feasterville, PA 19053
40 Exchange Place, Suite 701 New York, NY 10005

HARDSHIP REQUEST

DATE: ____/____/____

Re: Patient's Name: _____ Date of Service: ____/____/____

Test(s) ordered: *(see attached requisition)*

Diagnosis: *(see attached requisition)*

The above referenced patient has advised me that he/she does not have Health Insurance coverage and is unable to pay the full price for the routine diagnostic referenced laboratory tests that I ordered. The patient asked me to request, on his/her behalf, that the test(s) performed by your laboratory be billed to the patient at a reduced rate. Accordingly, I request that in this instance you bill my patient for the routine diagnostic test(s) indicated on the attached requisition at a reduced rate. I understand that a hardship request applies only to the above referenced date of service.

The above referenced patient is not an employee, nor is he/she related to any employee or member of this practice. Finally, I acknowledge that I have charged a reduced fee to the patient or any third party carrier for the office visit related to the above referenced date of service.

Sincerely,

Referring Physician Signature: _____

Address: _____

Hardship Request Approved

Hardship Request Denied

Billing Manager Signature