Ballad Financial Assistance Application Appeal

Today's Date: __________ **Patient Full Name:** ____
Last *First* *Middle*

Date of Birth: ______________ Is patient a minor? Yes or No

Phone Number: (_______) ________________________
Area Code *Number*

Guarantor and/or Account# (s): ____

Address: ____
Street Address Apartment/Unit #

____
City State Zip Code

_ Check here if patient is his/her own guarantor. Otherwise, add Guarantor information

Guarantor Name: ____
Last, *First* *Middle*

Phone Number: ( ) __________________________________
Area Code *Number*

Relationship to Patient: _________________________ **Date of Birth:** __________________________________

Address: ____
Street Address Apartment/Unit #

____
City State Zip Code

1. Please explain the reason(s) you are appealing and attach any documentation you believe supports your appeal.

   Mail your appeal to:

   Ballad Health Charity Department
   11511 Reed Hartman Hwy
   Blue Ash, OH 45241