NEOSHO MEMORIAL
REGIONAL MEDICAL CENTER

Financial Assistance Appeal Form

Your Name _____
Address _____
_____
_____
_____
Patient Number_____
Services Provided / Dates of Service _____
_____
_____

I am appealing the denial of Financial Assistance. I request that my Financial Assistance Application be reconsidered due to the following: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Date this Appeal is submitted: _____

Signature _____

If you have questions about this form contact the Patient Account Representative at (620) 432-5324.

Please mail the completed form to:

Neosho Memorial Regional Medical Center
Attn: Patient Financial Services
PO Box 426
Chanute, Kansas 66720