

## **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