(Date)

Name

Address

Provider Milwaukee Fire Department

Acct#: ********

Date of Service: ********

Dear (patient name),

We appreciate your concern regarding the above account and are sorry to hear of the financial hardship you are experiencing at this time. We also understand that on the date of transport you had no health insurance coverage to assist you in resolving this account.

****NOTICE****If you have received financial assistance through the hospital for the same date of service as stated above, then you can forward a copy of this letter (must have date of service and signed by a hospital representative) to the address below. At this time you do not have to complete the attached application or forward the required documentation. We will review the hospital's financial assistance letter and notify you via U.S. Mail of our determination.

If you did not receive financial assistance through the hospital, we have enclosed an application for financial hardship. Please fill this out completely AND be sure to attach the required documentation:

- Verification of current employment or unemployment status.
- A copy of your tax returns (W-2 forms, at least) for the current and previous year. Returns or W-2 forms for the current and previous year are preferred.

Please return to: Milwaukee Fire Department

1105 Schrock Road, Ste 610

Columbus, Ohio 43229

We will review and notify you via U.S. Mail of our determination. If you should have any questions or concerns, please do not hesitate to contact Patient Accounts at 888-987-2085. We are available Monday through Friday between the hours of 9:00am and 5:00pm EST. We look forward to assisting you in resolving this account.

Respectfully,

Patient Accounts