Main Line Health®
Well ahead.®

Internal use only
Facility Patient Number

Schedule B

Main Line Health Insurance Attestation

For MLH Emergency Room use only

Patient Name_____

Patient Date of Birth_____

Address:_____
Number and Street City State ZIP Country

SSN# (Last Four Digits): _____ Date of Service: _____

I hereby certify that I do not have insurance, nor the ability to pay for the above hospital services

☐ Initials: _____

I understand that by signing this document, I am applying for Financial Assistance.

☐ Initials: _____

If any information I have given proves to be untrue, I understand that the hospital or other entity of Main Line Health, may re-evaluate my financial status and I may become liable for charges.

☐ Initials: _____

Last Date Employed: _____ Family Unit Size: _____ Estimated Annual Income: _____
Required *Required*

I certify the above information is true and complete. I understand that willful falsification of information contained in this application will result in denial of Financial Assistance.

_____
Patient Signature

_____
Printed Name

_____
Date

If you have questions, please contact the MLH Business Office at: 484-337-1970 or request to speak to a representative in the MLH Financial Counseling Office at each hospital.

DISCLAIMER

Main Line Health reserves the right to request such information as pay stubs, income tax returns, bank statements, social security, and/or other liquid financial information deemed appropriate to determine qualification for assistance.