



MEDICAL BILL ASSISTANCE PROGRAM APPLICATION

MEMBER INFORMATION

Name

Email Address

Phone xxx-xxx-xxxx

Liberty HealthShare Program Participation

☐ Liberty Unite ☐ Liberty Connect ☐ Liberty Essential

No other Liberty HealthShare programs are eligible for the MBAP.

Membership ID#

Length of Continuous Membership

Applicants for the MBAP must be a Liberty HealthShare member in good standing for 12 continuous months immediately preceding request.

REQUESTED NEED

Please provide a detailed description of the medical bill assistance you are requesting.
Include provider(s) name, date(s) of service, treatment type, and total amount requested at the bare minimum.

Provider Name

Date of Service

Treatment Type

Total Amount Requested

Further Details or Description (place additional Provider Names and/or Services here)

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DEMONSTRATED FINANCIAL HARDSHIP

Please explain the financial hardship or situation that is prompting you to submit this application.

Please include, at minimum, the nature of the hardship, other financial aid options you have explored/applied for, and a detailed description of why this hardship has precluded you from the medical expense for which you are applying

Please explain why your request should be considered for sharing beyond your program sharing limits.

Have you reviewed the eligibility requirements for the MBAP?

☐ Yes

☐ No

SUPPORTING DOCUMENTATION

Please attach all applicable documents supporting your request (clinical notes, medical records, itemized bills or statements, financial hardship documentation, etc.)

ACKNOWLEDGMENTS AND ATTESTATION

- ☐ I understand that assistance is granted at the sole discretion of the ministry.
- ☐ I certify that the information provided in this application is true, accurate, and complete to the best of my knowledge.

Member Signature

Date