OHSU Health

Financial Assistance Appeal Request Form

Only fill out this form if we have made a decision on your financial assistance eligibility based on the financial assistance application you filled out and supporting documents you provided.

Patient Information			
Patient last name	Patient first name	Date of birth	MRN (if known)

Family Information

List any family members who also applied for financial assistance.

Names and dates of birth:

Appeal Information

What part of your application do you think we were wrong about based on our financial assistance policy?

- ☐ How income was calculated
- ☐ Household size
- ☐ Residency
- ☐ Other _____

You can find the OHSU Health Financial Assistance Policy at: www.ohsu.edu/financial-assistance

Write below why you think the financial assistance decision was incorrect. Be sure to include any documents that support your view.

Return this form and supporting documents to:

Mail:	**Fax:**	**Email:**
OHSU Patient Financial Services Mail code: RPB07 3181 S.W. Sam Jackson Park Rd. Portland, OR 97239-3098	503-418-2377	sfr@ohsu.edu

Questions about this form? Call 503-494-8551 for help.

Once we receive your appeal, we will respond within 3 weeks. We may need to ask you for more information before we can make a decision.