Brock Hughes
Medical Center
450 West Monroe Street
Wytheville, VA 24382

DISCOUNT FEE PROGRAM: UNINSURED PATIENTS

Services are not free, uninsured patients pay a discounted rate

TO BE SEEN AS AN UNINSURED PATIENT:

MUST MEET INCOME REQUIREMENTS

CANNOT HAVE HEALTH INSURANCE

MUST PROVIDE PROOF OF INCOME

MUST COMPLETE THE DISCOUNT FEE PROGRAM APPLICATION

Acceptable Proof of Income (POI):

- Federal Income Tax Return (1040, 1040A, 1040EZ), including Schedule C if self-employed
  - due by April 15th each year
- W-2's (but only if taxes were **NOT** filed)
  - due by April 15th each year
- Paycheck Stubs for most recent (1) one full month of work
  - due every 12 months
- Social Security Letter/SSA Statement
  - due after January 1st each year
- SNAP/WIC Benefits Letter
  - due each time the benefit period ends

Additional Information

- **Income Chart for Eligibility available: https://www.brockhughes.org/For-Patients OR contact the clinic.**
- **If you have No Income or are currently Homeless, please contact the clinic for additional instructions and special circumstance forms.**
- **If it appears you could be eligible for Medicaid according to your income, a Medicaid application will need to be completed or a Medicaid denial letter will need to be submitted to the clinic to qualify for the Discount Fee Program.**
- **Please contact the clinic if you would like assistance with applying for Medicaid.**

276-223-0558, ext. 8 | brockhughes.org | info@brockhughes.org

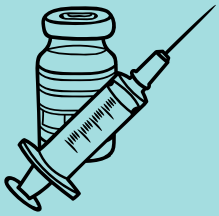
SELF-PAY FEES

as of 10-6-25
Services are not free, uninsured patients pay a discounted rate

Visits

$20.00 New Patient Visit
$10.00 Follow-Up or Acute Visit, once care is established
$25.00 Sports Physical or School Physical

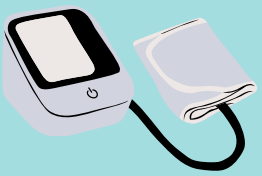
Additional Services During a Visit



$10.00 Rapid Testing (flu, covid, strep, pregnancy, UTI)
$10.00 Injection (B12, joint, allergy)
$10.00 Procedure (cryo, skin tag removal, ear irrigation, etc.)

Prescriptions & Chronic Care Supplies

$7.00 Prescription Processing Fee (per Prescription) *some prescriptions may have special pricing



$7.00 Test Strips (1 box)
$7.00 Libre Sensor
$7.00 Pulse Oximeter
$7.00 Lancets
$10.00 Insulin Syringes (1 box)
$10.00 Pen Needles (1 box)
$15.00 Blood Pressure Monitor (recommended by the American Heart Association)
$20.00 Nebulizer (includes tubing)

On-Site Laboratory Services:

- Quest Diagnostics staff perform venipuncture (lab testing) for BHMC patients on-site. Quest is responsible for the reading and billing of the labs.
- Quest Diagnostics offers UPP (Uninsured Patient Pricing). You do **not** need to complete an application to receive this reduced pricing.
- You will need to complete the Quest “Patient Financial Assistance Form”, to be considered for financial assistance, in addition to the Uninsured Patient Pricing. Once approved, the application is valid for 1 year.
- BHMC does not control this pricing and cannot give BHMC patients an estimate of costs.
- Quest Diagnostics can be contacted at 1-866-697-8378 with any questions about pricing and/or how to arrange a payment plan.

Quest Diagnostics™

276-223-0558, ext. 8
brockhughes.org
info@brockhughes.org

BROCK HUGHES MEDICAL CENTER (BHMC)
DISCOUNT FEE PROGRAM APPLICATION (Uninsured Patients)

The Discount Free Program is only available to patients whose income falls between 139-300% of Federal Poverty Level (FPL) and are uninsured.

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL): _____

Street or PO Address, City, State & Zip Code: _____

Date of Birth: _____ ***Marital Status:*** _____

How many people are in your family, including YOU? _____ List these people and **YOU** below, with the required information.

- Family Size=individuals in a household who are related and/or economically interdependent, please include who would be listed on a standard federal tax return.
- If someone can claim you as a dependent on their taxes, then list all other family members on that tax return.

FAMILY MEMBERS	Date of Birth	Relationship
		SELF

PROOF OF INCOME (POI):
Please select type AND provide documentation.

☐ Federal Taxes

☐ Paystubs (One-Month)

☐ W-2's (only if not filing taxes)

☐ Social Security Statement/Letter

☐ Unemployment Letter

☐ Food Stamps Award Letter

☐ No Income and/or Homeless

Do you have ANY type of medical insurance?

☐ Yes ☐ No

Do you have ANY type of prescription coverage?

☐ Yes ☐ No

Do you have ANY type of Medicaid?

☐ Yes ☐ No

Do you have Medicare?

☐ Yes ☐ No

Do you have Medicare, but not Part D (Prescription Coverage)?

☐ Yes ☐ No

I certify that the information I have provided in my application is accurate and true to the best of my knowledge and belief. I do not have ***prescription drug coverage*** *and authorize representatives of BHMC to share medical and financial information with other health facilities, Rx Partnership and pharmaceutical companies (or their designees) for eligibility verification and auditing purposes. I agree to inform the clinic if my household size, income, or insurance status changes. I recognize that if any information is found to be false or misleading, I will no longer receive services from BHMC. I understand BHMC is not a "free" clinic; there are discounted clinic and supply fees that will be payable to BHMC and there will be discounted fees owed to an outside laboratory, Quest Diagnostics, when having labs drawn.*

Signature of Patient or Legal Guardian:_____Date: _____

10-25, sl

BROCK HUGHES MEDICAL CENTER (BHMC)
DISCOUNT FEE PROGRAM APPLICATION (Uninsured Patients)

PATIENT-DO NOT COMPLETE THIS PAGE

For Office Use Only:

Family Size: _____

Income Documentation (POI) Provided: _____

Annual Household Income: $_____

Percent of FPG: _____

If at or below 138%, is a Medicaid Denial Letter on file at BHMC? Yes No
If No, patient needs to apply for Medicaid ASAP.

Signature of Patient Assistance Representative (screener): _____

Today's Date (of Approval/Denial for BHMC Discount Fee Program): _____

Reauthorization Date (**364 Days from the date the PATIENT signed this form)**

_____

NOTES/SPECIAL CIRCUMSTANCES: