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

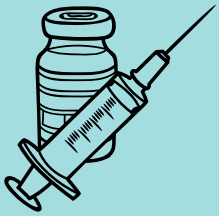
SELF-PAY FEES

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

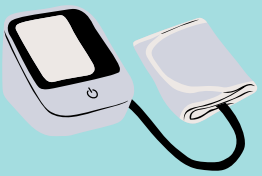
Additional Services During a Visit



$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:

- BHMC 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 ONE type AND provide documentation.

☐ Paystubs (recent & one-month minimum)

☐ Federal Taxes

☐ W-2's (only if not filing taxes)

☐ 1099's (only if not filing taxes)

☐ Letter from Public Agency (check type of letter below)

- ☐ Social Security (SSA/SSI)
- ☐ Virginia Employment Commission (VEC)
- ☐ SNAP
- ☐ Employer (must be signed by employer)

☐ No Income and/or Homeless (ask for Special Circumstance forms)

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: