CERTIFICATION OF DETERMINATION OF FINANCIAL NEED AND REQUEST TO OFFER PATIENT DISCOUNT

I certify that _____("Client") has determined that the patient listed below ("Patient") qualifies for a discount based on financial need.

Patient Name:	**Date of Service:**		
Patient Address:	**City:**	**State:**	**Zip Code:**

1. Based on this determination of financial need, Client discounted its fees off its gross charges for services provided to Patient by _____%.
2. Client requests that MD Labs offer this same discount on services ordered by Client for Patient.
3. Based on Client's determination that Patient is indigent, uninsured or under insured and thus qualifies for the percentage discount stated above, MD Labs agrees that it will bill Patient at the above stated discount for any amount owed to MD Labs for laboratory services ordered by Client.
4. Client agrees to make available to MD Labs for inspection, upon MD Labs request, Client's billing records regarding Patient, including any documentation related to Client's determination of Patient's financial need or lack of insurance. MD Labs agrees to make available to Client for inspection, upon Client's request, MD Labs billing records regarding Patient.
5. I further certify that I am duly authorized to make the representations and request stated herein on behalf of Client.

Name of Client:	**Approved by MD Labs**
Signature:	Signature
Print Name:	Print Name:
Title:	Title:
Date:	Date:

Send completed requests to:

- FAX to: **775-499-5146** Attn: Compliance
- Mail to: MD Labs 10715 Double R Blvd, Ste. 102 Reno, NV 89521 Attn: Compliance

If you have any questions or concerns please call our Compliance Department at **775-499-5150 ext 125**.