

UW Medicine

Patient Accounts & Support Services

Date:

Re: Settlement Reduction/Waiver Request

Requestor:

Patient Name:

Account Reference:

Date of Service(s):

This is in response to your settlement reduction/waiver request to UW Medicine. We need more information to review your request. **Provide ALL required information below:**

Facility Requested <i>(check box)</i>	Current Balance:	Proposed Payment Amount <i>(each facility):</i>
Harborview <input type="checkbox"/>	\$	\$
UWMC-Montlake <input type="checkbox"/>	\$	\$
UW Physicians <input type="checkbox"/>	\$	\$
UWMC-NW Campus <input type="checkbox"/>	\$	\$

Case Settled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Offer/ Settlement Amount: \$		
Attorney Fee: \$	Attorney reduced fee? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fee after reduction:\$	
Employment Status:	Monthly Income: \$	Patient's compensation: \$	
PIP coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has PIP exhausted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Wage Loss: \$	
ALL other medical provider(s)	Current Balance	Reduction request accepted?	Net Amount Owed (after reduction)
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
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	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$

Please allow up to 14 business days to review and respond to your request.

If you have any questions, please contact us directly via email at passroi@uw.edu

Sincerely,

Patient Accounts & Support Services