CARILION CLINIC

Verity Card Application

Patient Name: _____
DOB: _____
Address: _____ City_____, State_____, Zip code_____

Does patient have Prescription Insurance: YES ☐ NO ☐

Does patient have Medicare Part A and B? YES ☐ NO ☐

How Many Members in patients Household:

Total Monthly Income of all household members:

I _____ attest that the following information provided is accurate to my knowledge. Eligibility for assistance with the Verity Card does not constitute insurance. Eligibility determination will not affect other care and services offered by Carilion Clinic. Coverage can be revoked at any time if insurance is obtained or household income increases to greater than plan limits.

_____ _____
Patient Signature Date

For Office use only:	
Approver Name:	Date of Application Review:
If Denied, reason:	Date of Deinal?