Garnet Health

Guarantor Name:
Guarantor Address:

Patient Name:
Hospital Account Number:
Service Date:
Hospital Account Balance:

Dear

Garnet Health has received and reviewed your application for financial assistance.

Based on the information you gave us, your application has been denied as you do not qualify for the program. The patient responsibility remains $ for this visit.

If you have any questions regarding this determination or would like to make payment arrangements, please contact the Financial Advocate Unit at

Thank you for choosing Garnet Health as your healthcare provider.

Sincerely,

Patient Financial Services