



BOONE MEMORIAL HEALTH

BMH Screening Mammography Assistance Application

October 2026 | Free screening mammography for qualifying uninsured women

This brief application determines eligibility for the October 2026 screening program. It does not replace BMH's full Financial Assistance Application for other services. Please complete the application before the screening mammogram is performed. **Submit completed application to a Boone Memorial Hospital information desk, Radiology Department, Business Office or by email to business.office@bmh.org**

REQUIRED MINIMUM INFORMATION

Patient name: _____ Date of birth: _____

Address: _____ Phone: _____

_____ Cell Phone: _____

Scheduled date: _____ Ordering provider: _____

1. INSURANCE STATUS

☐ I do not have active Medicare, Medicaid, employer, Marketplace, or other health coverage that will pay for this screening mammogram.

☐ I authorize BMH to verify whether I have active coverage for this service.

2. HOUSEHOLD AND INCOME

Number of people in household: _____ Estimated annual gross household income: \$ _____

Income source(s), if any: _____

3. PATIENT ATTESTATION

I certify that the information provided is true and complete to the best of my knowledge. I understand that this assistance applies only to approved screening mammography services. Diagnostic imaging and other follow-up services are separate and may be billed. BMH financial assistance may be available for eligible patients.

Patient signature: _____ Date: _____

BMH USE ONLY - DETERMINATION

☐ Coverage verification completed

Verified by / date: _____

Household size: _____ FPG percentage: _____ % Approved program threshold: 240% FPG

☐ Approved

Reason, if denied: _____

☐ Denied

Approver

Signature: _____ Approved date: _____

☐ Scanned to Patient Acct# _____ Scanned by (Initials:) _____

Program covers CPT 77067 and CPT 77063, including BMH technical and professional interpretation charges. See program policy for limitations.