

SPARTANBURGRegional Healthcare System

Provider Statement

Patient Name:		Account Number:	
This is a statement explaining monthly support from you with dollar amounts of the care that is provided to the patient. This includes room and board, personal expenses, etc.			
By filling out this form, you, the patie patient to live in your home at no co This in no way makes you responsible	st or providing help	with the cost of liv	ng the patient either by allowing the ving for the patient listed above.
If you have questions or need help completing this form, call Spartanburg Regional Healthcare System Patient Financial Services at: 864-596-1001 or 800-281-5346.			
Provider's Name	Relationship to Patient		Contact Number
I provide the patient indicated above with the following estimated dollar amount per month (if no dollar amount given, application will be denied):			
Expense	Monthly Amount		Comment (if applicable)
Housing			
Food			
Personal Expenses			
Other			
Total			
Do you claim the patient on your tax return?			
If yes, please send a signed copy of the your tax return.	he provider's most	recent year's tax re	eturn. Please include all pages of
If no, please include the first page (fo	orm 1040A) of your	tax return to show	you are not claiming the patient.
Provider's Signature		Patient's Signature	
Date Time		 Date	 Time

2078 (Rev. 08-22) EPIC DOC TYPE: PROVIDER STATEMENT