UNINSURED PATIENT CARES ACT ATTESTATION FORM

My signature below affirms that I currently do not have medical coverage and therefore I am considered to be uninsured on the date of COVID 19 testing.

I willfully supply my information to siParadigm to submit for payment of COVID-19 testing through the Cares ACT Uninsured Patient Program.

I certify under penalty of perjury and pursuant to the state and federal laws that the information provided in here is true and accurate.

____

Last Name First Name Gender

____________________________________ ________________________

Social Security Number Date of Birth

____________________________________ ________________________

Email Address Phone Number

____

Street Address City State Zip Code

____ _________________

Drivers License # Issuing State

____ _________________

Patient Signature Date

____ ________________

Parent/Guardian Signature Date