



Discount Request Form

Please send this form in with your payment to better assist us in applying your discount appropriately. Feel free to use the self addressed envelope that came with your statement, or send this for with your payment to:

Springfield Hospital
ATTN: PFS
25 Ridgewood Road
Springfield Vermont 05156-2003

Patient Name (Last, First, Middle Initial) _____

Patient account number _____

Total billed amount \$ _____ *(amount you are being billed)*

Total discount amount \$ _____ *(see discount schedule to determine this amount)*

Total payment enclosed \$ _____ *(amount you are sending us with this paperwork)*

For assistance in filling out this paperwork, please call at 802-885-7631 or 802-885-7630 between 8:00 AM and 4:30 PM. We are here to help you!