

Request for Financial Aid Packet

Please remit to Fax # 323 888-1591

Number of planned sessions _____

Requested Funds \$ _____

Loan
Grant

Doctor IHA Member# _____
(Provider or General Member)

Clinic IHA Member# _____
(Corporate or General Member)

Patient Name

Address

Phone/ email/ web

Signature

Patient Member # (required)

Doctor Name

Address

Phone/ email/ web