PROVIDENCE
St. Mary
Medical Center

LIFESAVER FUND

Screening Mammogram Fund Application

(A fund to assist the low-income/uninsured obtain screening mammograms)

Name: _____ Date: _____

Address: _____

City/State/Zip: _____

Phone: (Home) _____ (Other) _____

Date of Birth _____ Age _____

Primary Health Care Provider _____

Date of Last Mammogram _____ Place _____

Breast implants? _____ Personal history of breast cancer? _____

Applicant Signature: _____

Please list dates/ times you ***prefer*** for an appointment. *(Your appointment will be made upon approval of this application. You will be contacted by phone with the date/time.)*

_____ _____

_____ _____

Send or fax to: Providence St. Mary Medical Center
Attn: Cancer Center
P.O. Box 1477
Walla Walla, WA 99362
Phone 509.897.5700 Fax 509.897.5705

THIS SECTION FOR OFFICE USE ONLY

Approved _____ Denied _____ Signature _____

Service(s) Approved:	Date of Service:	Signature of Approver
_____	_____	_____
_____	_____	_____
_____	_____	_____