University of California
Santa Barbara

FEE WAIVER REQUEST

Student Health
Service

To request a fee waiver, please fill out the following form **completely, legibly and concisely.** Your request will be reviewed by the Student Health Service (SHS) Billing Officer. Please allow at least one week for notification. **You may also request a waiver by email, but you MUST include ALL the information below.** **west-j@sa.ucsb.edu** Thank you.

NAME _____ Phone # (____)_____

Perm # _____ Email _____

You will be notified by email as soon as a decision has been made on your request.

Local mailing address _____
street address city/town zip code

Type of fee charged: missed appointment fee ☐ visit fee ☐ other ☐ _____
Please explain

Please check one of the above.

Date of your appointment _____ Time of your appointment _____

Name of practitioner _____

Please explain below, as clearly and concisely as possible, why you would like to have your fee waived:

PATIENT SIGNATURE _ DATE _____

Please allow up to **two weeks** for a response to your request.If you need more room, please use the back of this form.

Please drop off form in the container provided at the Information Kiosk in the Student Health lobby.

Or mail to: University of California
Student Health, M/C 7002
Attn: Billing Officer
Santa Barbara, CA 93106-7002

Or fax to: 805-893-3861

FOR OFFICIAL USE ONLY

Request Denied ☐ Request Accepted ☐ Date _____ Staff Signature _____

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