Medical Debt Resolution Program Training Manual

Spring 2012

The Access Project
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BACKGROUND INFORMATION

About The Access Project

The Access Project (TAP) has served as a resource center for local communities working to improve health and healthcare access since 1998. The mission of TAP is to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. TAP conducts community action research in conjunction with local leaders to improve the quality of relevant information needed to change the health system. By supporting local efforts and community leaders, we are dedicated to strengthening the voice of the underserved in policy discussions that directly affect them.

The Access Project's fiscal sponsor is Third Sector New England, a nonprofit with more than 40 years of experience in public and community health projects. TAP is affiliated with the Heller School for Social Policy and Management at Brandeis University.

The Access Project and the truth about medical debt: Before 2000, not even health policy experts worried much about medical debt. It was assumed that charity care could be found in an emergency room, and that simply allowing bills to go unpaid brought few problems for the debtor.

But with the ground-breaking publication of "Paying for Care When You're Uninsured," The Access Project revealed the truth about medical debt—that it creates financial distress and actually increases health problems for millions of people. The study revealed, for the first time, the shocking extent of the problem. Many of those with debt said it would deter them from seeking health care in the future.

Since that time, TAP has played a crucial role in building awareness of the causes, extent and consequences of medical debt. Through its interviews and research, TAP started the national dialogue on medical debt—and the search for solutions. Repairing the American health care system must be a national priority.

The Access Project in action: TAP has worked tirelessly to expose how policy decisions and business practices lead to medical debt. Our studies motivated changes in hospital pricing and charity care that previously discriminated against the uninsured. Our effective use of research combined with personal stories compelled the American Hospital Association to issue new guidelines on medical debt collection, and helped build support for laws passed in several states that gave patients expanded rights. TAP has challenged the notion of "consumer driven health care" which has allowed insurers to shift costs to individuals through higher premiums, deductibles and co-payments. In addition, TAP works directly with individuals, offering free counseling and debt negotiation services to help relieve their medical debt.

Looking Toward the Future, Finding Policy Solutions: The Access Project has done more than merely raise awareness of this national crisis by focusing on inadequate coverage, reduced health care access and more costly credit. We have identified real solutions to this problem. We must strengthen consumer protections in private insurance coverage and provide financial assistance programs to aid people in paying medical bills. The Access Project will continue to raise the debate on medical debt in local, state and national policy discussions on health care and economic development. We will bring help and counsel to those in need. It will give power to consumers, bringing the voices of people hurt by medical debt into the policymaking arena.

BACKGROUND INFORMATION

The Prevalence and Consequences of Medical Debt

National Context

Since 2000, The Access Project (TAP) has been studying the issue of medical debt—that is, debt resulting from healthcare expenses. Research by TAP and other policy groups has clearly shown that medical debt is widespread among both the uninsured and the insured and that its consequences are serious.

According to a 2010 Commonwealth Fund study, one-quarter of adults under the age of 65 (24%) had medical debt or medical bills being paid off over time. Among these people, nearly two thirds (59%) were insured when they sought the care that resulted in medical debt or medical bill problems.[1] Medical debt creates major barriers to accessing care for both the insured and uninsured: 28 percent of the privately insured with medical bill problems postponed care and 30 percent skipped a test or treatment due to cost, figures similar to those for people without insurance.[2] Other studies have shown that medical debt and medical bill problems create serious long term financial problems, such as housing problems, exhaustion of savings to pay for care, or inability to obtain credit.

The Patient Protection and Affordable Care Act (ACA)

Passage of the Patient Protection and Affordable Care Act offers numerous opportunities to expand insurance coverage, increase safeguards against inadequate coverage, and reduce unneeded trips to the emergency room—all key underlying causes of medical debt. Under the ACA, which was passed in March 2010 and will be implemented over the next few years, insurance expansion is projected to cover nearly 32 million Americans who are now without coverage.

New opportunities will extend coverage to Americans through both public programs and private insurance. Insurance quality and access should improve, leaving fewer Americans with unaffordable medical expenses. Organizations working with low and moderate income people must take full advantage of the ACA's protections.

Certain provisions of the ACA have particular salience for those concerned with financial opportunity and security. They include:

Medicaid and Safety Net Expansions

Roughly half of the newly-insured will be enrolled in Medicaid and the Children's Health Insurance Program (CHIP). By 2014, the Medicaid program will be expanded to cover all non-Medicare eligible individuals under the age of 65 with household incomes under 133 percent of the federal poverty level ($14,485 for an individual and $30,657 for a family of four in 2012 dollars). The ACA increases federal support for community health centers by creating an $11 billion fund to support expanded operational capacity, as well as construction and renovation of clinics. This support will allow clinics to serve more Medicaid beneficiaries as well as undocumented immigrants and those who will remain uninsured, a point of special importance to Illinois.

Expansion of public programs will help millions of Americans achieve access to care and avoid financial ruin, given the out-of-pocket cost protections that are typically associated with these

The Prevalence and Consequences of Medical Debt (con't)

programs. A recent Oregon study found that Medicaid coverage increased access to needed care while decreasing the likelihood of out-of-pocket costs, medical debt or having a medical bill sent to collection.[3] The study also found that Medicaid beneficiaries reported improved physical and mental health.

Creating Health Insurance Exchanges:

Individuals without affordable employer-sponsored coverage will be able to purchase private insurance coverage through a health insurance exchange. This coverage will be made more affordable for those with household incomes of under four times the federal poverty level through using premium subsidies, offering tax credits and by limiting out-of-pocket expenses. Small businesses with up to 100 employees will be able to purchase health insurance coverage for their employees through a special small business insurance exchange. As a temporary measure, beginning in the 2010 tax year 2010, businesses fewer than 25 employees and average annual wages of less than $50,000 were eligible for a tax credit if they paid a minimum of half of the cost of coverage for their employees.

Protections for those with Private Coverage:

The implementation of provisions aimed at improving the quality of health insurance has already begun. After the law's passage, protections requiring that insurers spend a minimum percentage of the premium dollar on medical services or provide rebates to policyholders, as well as eliminating lifetime limits on insurance coverage, have benefited tens of millions of Americans. To protect against unwarranted insurance premium rate hikes, states will begin to review premium increases and require insurers to justify rate hikes. As a means of ensuring the maximum protection from private insurance coverage, Americans will be guaranteed the right to appeal insurance company coverage decisions to an independent third party.

Keeping Young Adults Insured:

Beginning in the fall of 2010, health insurers had to offer coverage to enrollees' children up to the age of 26 regardless of whether the children were students, dependents, or lived with the parent. Many insurers adopted this provision soon after the ACA was enacted. The US Department of Health and Human Services estimates that 1.2 million young adults will take advantage of this provision and sign up for coverage in 2011, and current take-up rates suggest that this projection is on track.

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[1] Commonwealth Fund Biennial Health Insurance Survey 2010.

[2] C. Hoffman et al., "Medical Debt and Access to Health Care," Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, September 2005.

[3] Amy Finkelstein et al., "The Oregon Health Insurance Experiment: Evidence From The First Year," The Oregon Health Study Group Working Paper 17190, National Bureau Of Economic Research, July 2011.

BACKGROUND INFORMATION

Glossary

Action Plan: a specific procedure of method to achieve results called for by one or more objectives.

Balance Billing: billing a patient for charges not paid by their insurance plan because the charges are above the usual and customary rate or because the insurer considered a procedure medically unnecessary.

Cap, out-of-pocket: the greatest amount that an insurance plan will pay per service, per year, or per person.

Co-insurance: a percentage of the charge for a service (after the copayment) that you must pay for services you receive. A 20% coinsurance rate means you pay 20% of the charge. The plan pays the remaining 80%.

Claim: a demand to the insurer by, or on behalf of, the insured person for the payment of benefits under a policy.

Co-payment: additional fee you pay the doctor, hospital, or pharmacy at the time you receive services.

Collection agency: a business that pursues payments on debts owed by individuals or businesses. Most collection agencies operate as agents of creditors and collect debts for a fee or percentage of the total amount owed.

Cost Sharing: insurance policy provisions that require insured people to pay through deductibles, co-payments, and co-insurance, a portion of their health insurance expenses.

Creditor: one to whom money or its equivalent is owed.

Deductible: an amount that you must pay for services you use before the insurer begins to pay for services under this plan. This amount does not include the premium.

EOB (Explanation of Benefits Form): a statement describing medical benefits and account activity, including explanation of why certain claims may or may not have been paid.

Exclusion: services or supplies not covered under a health plan.

Health Insurance Portability and Accountability Act (HIPAA): a 1996 law that sets responsibilities for group health plans, including self-funded medical plans. It also establishes regulations for the use and disclosure of Protected Health Information (PHI).

MDRP: The Access Project's "Medical Debt Resolution Program."

Glossary (cont')

Medicaid: a program in the United States, jointly funded by the states and the federal government, that reimburses hospitals and physicians for providing care to qualifying people who cannot finance their own medical expenses.

Medical debt: debt incurred due to health care costs and expenses.

Medical Provider (AKA: "Provider"): a physician, hospital, laboratory, pharmacy, ambulance company, or other organization that provides health care goods or services.

Medically Necessary: term used by insurers to describe medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice.

Medicare: a program under the U.S. Social Security Administration that reimburses hospitals and physicians for medical care provided to qualifying people over 65 years old.

Out-of-pocket maximum: the greatest amount you could pay annually for medical costs. This usually excludes certain medical expenses, particularly co-payments. This means that these services don't count towards reaching the out-of-pocket maximum.

Pre-authorization: a requirement by the plan to get permission from a network primary-care doctor to see a specialist. *See referral*.

Pre-existing condition: a health condition that one had prior to receiving coverage through an insurance policy

Premium: a monthly payment you make to purchase and maintain a health plan. You pay this amount even if you do not use services under this plan.

Primary Care Provider: a physician chosen by or assigned to a patient, who both provides primary care and acts as a gatekeeper to control access to other medical services.

Private Insurance: health insurance purchased on the private market, either through an employer or directly from a company.

Protected Health Information (PHI): any information about health status, provision of health care, or payment for health care that can be linked to an individual.

Provider: see entry for "Medical Provider."

Provider, In-Network: physicians, hospitals, and other medical providers who have a contract with a managed care plan.

Glossary (cont')

Provider, Out-of-Network: physicians, hospitals, or other providers who do not have a contract with an insurance company.

Public Program: a health coverage program paid for by a government-based funding stream that can be federal, state-wide, or local. These programs have eligibility requirements that set minimum criteria for who can and who cannot benefit. Medicaid, Medicare, and the Palm Beach County Health Care District are examples of public programs.

Referral: a requirement by the plan to get permission from a network primary-care doctor to see a specialist.

Secured Debt: debt backed or "secured" by collateral to reduce the risk associated with lending. An example would be a mortgage, your house is considered collateral towards the debt. If you default on repayment, the bank seizes your house, sells it and uses the proceeds to pay back the debt.

Self-funding (Self-insurance): a medical benefit plan established by an employer or employee group (or a combination of the two) that directly assumes the functions, responsibilities, and liabilities of an insurer.

Uncovered Service: a medical service not paid for by health insurance because of a payment cap or exclusion in the policy (network, service, pre-existing condition, etc.)

Underwriting: process by which an insurer determines whether and on what basis it will accept an application for insurance.

Unsecured Debt: debt that does not involve collateral and is not backed by an asset. This type of debt is the result of money owed, for example, to a credit card company, who cannot seize any of the consumer's possessions if s/he does not pay off the balance. Medical debt is unsecured debt.

Waiting period: is a period of time which one must wait in order for a specific action to occur, after that action is requested or mandated. Incidents which occur during this time are not claimable.

MEDICAL DEBT PATHWAY

The Access Project Medical Debt Pathway

Initiation Step: What problem needs to be solved?

Many Illinois residents are struggling with medical debt owed to local providers. Some people are being pursued by collections agencies, and others have medical bills on their credit reports.

Action Step 1: Educate

Give reference materials to client:

- Brochure-*Your First Steps in Dealing with Medical Bills*
- Brochure-Guide to Resolving Medical Debt

Action Step 2: Collect Medical Debt Information

- Fill out Intake Form
- Collect additional medical debt information using Medical Debt Worksheet I
- File Medical Debt Worksheet I and Intake Form

Action Step 3: Develop an Action Plan

- Review intake form and Medical Debt Worksheet I for completeness and identify missing information
- Assess case information and work with client to develop an Action Plan using Medical Debt Worksheet II
- Make referrals to partner organizations, as necessary
- Support client in carrying out action plan

Action Step 4: Follow-up, Confirm, and Support

- Follow-up with client in 2-3 weeks to review progress on Action Plan
- Collect missing information to update Medical Debt Worksheet I and Intake Form
- Identify client's barriers to follow-through and provide additional support to help resolve medical debt
- Review and revise Action Plan
- Support client in carrying out Action Plan
- Make referrals to partner organizations, as necessary

Completion Step: Case Resolution

- Client has taken actions to resolve his or her medical debt
- Medical debt has been eliminated, reduced, or re-negotiated into a manageable payment arrangement
- Enter debt resolution or outcomes in database
- Case remains open if client has additional unresolved medical bills; close case if all medical debts have been resolved or if the client is unreachable

MEDICAL DEBT PATHWAY

Initiation Step: What problem needs to be solved?

Many Illinois residents are struggling with medical debt owed to local providers. Some people are being pursued by collections agencies, and others have medical bills on their credit reports.

Medical debt profiles

Primary Focus

- IL residents who owe medical debt to Chicago-based providers
- IL residents who have medical bills in collections
- IL residents who have medical bills on their credit reports

Secondary Focus

- IL residents who owe medical debt to providers outside of IL
- Non-IL residents who owe money to Chicago-based medical providers

MEDICAL DEBT PATHWAY

Action Step 1: Educate

Give reference materials to client:

- Brochure-*Your First Steps in Dealing with Medical Bills*
- Brochure-*Guide to Resolving Medical Debt*

Guide clients through each of the reference materials

Inform client about:

- Dealing with bills right away and not ignoring them
- The financial and health access consequences of unpaid medical bills
- The dangers of charging medical bills on credit cards, taking out loans, or borrowing against an asset such as one's home or car
- The right to appeal denied private insurance claims
- Potential eligibility for public programs, even if privately insured

Refer clients to appropriate resources:

- Apply to the Illinois Healthcare and Family Services (HFS), Medical programs such as Medicaid, All Kids, FamilyCare, Moms & Babies or HFS Medical Benefits
- Appeal denied insurance claims by filing an internal appeal through your insurance company or HMO. If not successfully resolved, go through the Illinois Department of Insurance Health Carrier External Review process, if eligible
- Seek legal assistance from legal assistance attorney , if applicable
- Other organizations to help with financial stability or housing security

Speak to clients about communicating with medical providers about:

- Charity care
- Negotiating medical bills
- Arranging affordable payment plans

MEDICAL DEBT PATHWAY

Action Step 2: Collect Medical Debt Information

- Fill out Intake Form
- Collect additional medical debt information using Medical Debt Worksheet I
- File Medical Debt Worksheet I and Intake Form

Key questions:

- What was the medical situation that led to the client's medical debt?
- What was the client's insurance status when she/he sought health care?
    - o Determine the client's insurance status on the date of service that each medical bill was incurred (Uninsured, private insurance, or public coverage)
- To which medical providers does the client owe medical bills and how much?
- If the debt is now owed to a collections agency, where did the client originally seek care?
- Does the client have medical debt on his/her credit report?
    - o Ask the client to see a copy of his/her credit report. [See section, *Medical Bills on Credit Reports* for more information]
    - o If the client does not know the original medical creditor, write to the collections agency to "verify" the original creditor. However, if the bill is more than a couple of years old, then this may not be an appropriate action [For more information and a sample letter, see section, *Medical Bills in Collections*]
- Has the client faced any health access or financial consequences due to this debt?
- What actions has the client already taken to deal with his/her medical debt?

MEDICAL DEBT PATHWAY

Action Step 3: Develop an Action Plan

- Review intake form and Medical Debt Worksheet for completeness and identify missing information
- Assess case information and work with client to develop an Action Plan
- Make referrals to partner organizations, as necessary
- Support client in carrying out action plan

Overview:

- Help the client to develop an Action Plan to gather information and materials from insurers, public programs, medical providers, and collections agencies. Not every item will be relevant for every case
    - o See Action Plan Worksheet I: Gathering Information
- Help the client decide what strategic steps to take to begin resolving medical bills
    - o See Action Plan Worksheet II: Steps to Take
- Advise client to keep good records
    - o Use a notebook or pad of paper to write down information and keep it organized
    - o Keep all papers in one place
    - o See Action Plan Worksheet III: Guide to Making Effective Phone Calls
    - o Whenever clients call their medical provider, insurance company, public program, or collections agency, tell them to write down:
        - Date and time of the call/meeting
        - Name of person they speak with
        - Job title of person they speak with
        - Contact information for person they speak with
        - Questions they asked
        - Answers they received

Key Points:

- If your client had private insurance that denied payment for a medical claim, see the section on Private Health Insurance Appeals
- Inquire with medical providers about charity care and financial assistance
- Medical bills are negotiable! However, leveraging other resources, such as insurance appeal rights and eligibility for public programs, are important first steps

MEDICAL DEBT PATHWAY

Action Step 4: Follow-up, Confirm, and Support

- Follow-up with client in 2-3 weeks to review progress on Action Plan
- Collect missing information to update Medical Debt Worksheet and Intake Form
- Identify client's barriers to follow-through and provide additional support to help resolve medical debt
- Review and revise Action Plan
- Support client in carrying out Action Plan
- Make referrals to partner organizations, as necessary

Common Difficulties in Action Step 4:

- Reaching clients for follow-up
- Updating gaps in information regarding the client's medical providers, collections agencies, public programs, and insurance companies.
- Getting clients to follow through with an action plan

Key points:

- Collect any new information from the client and review the Action Plan
- Identify which action steps have been accomplished, which need to be updated or changed, and what new steps should be added
- Help the client identify any additional information to collect
- Update the Action Plan
    - o Client may need to repeat a few steps if he/she did not fully complete the original Action Plan
- If you and the client determine that you may need to call a medical provider or insurance company on his/her behalf, fill out a HIPAA form and make two copies: one for your file, one for the specific institution that you will be contacting
- Continue the follow-up step until all of the client's medical bills are resolved

MEDICAL DEBT PATHWAY

Completion Step: Case Resolution

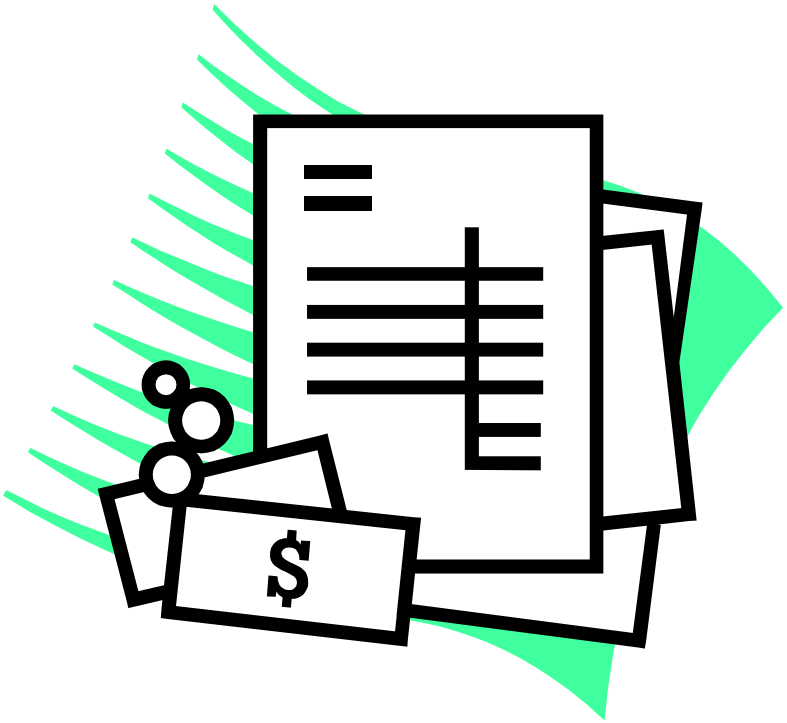
- Client has taken actions to resolve his or her medical debt
- Medical debt has been eliminated, reduced, or re-negotiated into a manageable payment arrangement
- Enter information on resolution of medical debt into database
- Case remains open if client has additional unresolved medical bills; close case if all medical debts have been resolved or if the client is unreachable

Key points:

- The payment amounts listed beside each Payor (client, provider, insurer, public program) should add up to the original amount of the medical bill
    - o In some cases, a portion of a bill may be left unpaid
    - o Don't be afraid to round numbers
    - o Sometimes clients won't know exactly what happened or who paid a medical bill—do your best to estimate the amounts paid
- If a medical debt appeared on a client's credit report, ask the client to pull another credit report a few months later to verify that removal actually happened (See section, *Medical Bills on Credit Reports*)

The Access Project

Guide to Resolving Medical Debt



Part One:

Working with Medical Providers

April 2008

The Medical Debt Resolution Training Program was made possible by generous funding from:

The Annie E. Casey Foundation

The Access Project ● 89 South Street ● Suite 202 ● Boston ● MA ● 02111
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Paying Medical Bills: Overview

Do

- Deal with the situation as soon as possible. As soon as you receive a medical bill, call up your provider about the bill even if you feel like you can not afford it
  - You may be eligible for a public program or provider-based financial assistance
  - Work directly with the billing office of your medical provider to negotiate bill discounts and payment plans.
  - It is much harder to negotiate bills that have been sent to a collections agency
- Call the billing office of your medical provider and ask about:
  - Public programs that may cover past bills
  - Screening for charity care
  - Getting future care
    - Will the provider continue to see patients if past bills are not paid
    - Does the provider require pre-payment for future care

Don't

- Don't ignore medical bills—they do not go away!
- Don't agree to a monthly payment plan that you can not afford

Be careful about…

- Paying medical bills before paying rent/mortgage, utilities, food, or other necessities
- Borrowing against your home or another asset to pay for medical bills
- Using a credit card to pay medical bills unless you can pay off the balance at the end of the month

About Your Medical Bills

Getting and understanding your medical bills

- Call or write your provider to get an ***itemized bill***
  - The bills you normally get in the mail are not itemized, and do not have complete information
- Ask your provider for a copy of your ***patient medical records*** if you believe there was a billing error
  - You may be charged copying fees for your records
  - Compare your medical records to your itemized bill to see if there are any billing errors
- Look carefully at your medical bills and make sure all of the information is correct. For example:
  - Patient name and address
  - Date(s) of service
  - Insurance number and other insurance information
  - Length of stay for inpatient care
  - Accurate list of received services

Challenge billing errors!

- Call your provider's billing office and ask them to correct any mistakes that you found
- If they do not correct the billing errors, ask to speak with a patient accounts manager and repeat your request
- If making a verbal request does not work, ask about the provider's "grievance" or "appeal" process for disputing mistakes on medical bills
- If there is not a formal process, write a letter to explain why you believe there was a billing error. Send the letter to the provider's Chief Financial Officer (CFO) or Chief Executive Officer (CEO). Send copies to the manger of billing, your state Attorney General, and any relevant advocacy groups

Working with Providers

Tips for calling your health care provider

- Who do you speak with?
  - Begin with the clerk who answers the phone in the billing office
  - Ask to speak with a manager in the billing department (for example, the ***Manager of Patient Accounts*** or ***Manager of Credit and Collections***)
  - Ask the manager about charity care, negotiating bills
  - Ask to speak with a ***Financial Counselor*** to apply for public programs
  - Climb up the administrative ladder and speak with the Chief Financial Officer (CFO), if necessary
- Always be polite to the billing people, even when frustrated
- If you are unable to call for yourself, a friend, family member, or other advocate can call the provider on your behalf
  - You will need to be on the phone to give permission for the provider to speak with someone else about your case
  - A three-way call can work well
  - You can also fill out a written release form and send it to the provider
  - Make sure the other person has complete information about your case

Keep good records

- Whenever you speak with someone about your medical bills, write down:
  - Date and time of the call/meeting
  - Name of the organization or institution
  - Name of person you speak with
  - Job title of person you speak with
  - Contact information for person you speak with
  - Questions you asked
  - Answers you received

SUGGESTED LANGUAGE TO USE WHEN CONTACTING THE BILLING OFFICE OF A MEDICAL PROVIDER:

"Hi, I'm following up about my medical bill. I'm calling to arrange payment, but I want to make sure that everything in my account is correct before paying."

"Please send me a copy of my itemized bill."

"May I please speak with the Manager of Patient Accounts or the Manager of Credit and Collections?"

"Please put my bills on hold while I review the details of my bill and update the status of my account to 'pending'."

Charity Care

Asking about charity care

- You may be eligible for medical provider-based charity care or financial assistance that will help to pay past medical bills.
- Call your provider's billing office and ask for a written copy of the charity care and financial assistance policies.
- Ask for charity care and financial assistance applications.
- Look at your medical bills: do they mention availability of "financial assistance programs"?
- In general, most hospitals have charity care and financial assistance policies. Many other medical providers, such as ambulance companies, doctors' groups, and laboratories, also offer this kind of assistance.

Hospitals and charity care

While most hospitals offer charity care to their patients, ***non-profit hospitals*** have extra responsibility to do so because they receive tax breaks

- In 2003, the American Hospital Association (AHA) released guidelines for hospital billing and collection practices. The guidelines say:
  - Hospitals should offer discounts to patients who can not afford their bills
  - The hospital should have publicly available information about charity care and other payment discounts
- If hospital personnel do not know details about the charity care policy and the AHA guidelines, ask to speak with a billing manager who knows about them
  - Inform the hospital that you know about the guidelines
  - Ask to see a copy of the hospital's charity care policy

Negotiating Your Bill

Negotiating with providers: why it is worth a try

- Medical bills can contain errors
- Uninsured people are expected to pay the highest prices, but the charges are often negotiable
- Insured people with uncovered services may be charged like they are uninsured
- People with different insurance products may be expected to pay different amounts for the same services
- You might be eligible for charity care and not know it
- Providers may want to get something rather than nothing

Tips about negotiating discounts

- Medical providers often offer payment discounts and may completely forgive bills in some cases
- Always ask for a discount
- Explain hardships that you face—a personal story can make the difference
- Build relationships with billing managers

SUGGESTED LANGUAGE TO USE WHEN NEGOTIATING BILLS

"I would appreciate it if my charges could be reduced to the NEGOTIATED RATE—the amount that private insurance companies or Medicare would pay for the services."

"I want to pay my medical bills but the charges are unaffordable."

"Could we settle the account for a discounted price?"

"I can afford to pay $___ per month." (name a discounted price that you can reasonably afford)

Negotiating Your Bill (cont.)

Negotiating payment plans with a provider

- Decide in advance how much you can realistically pay per month for each bill.
- Many providers ask patients to pay off an entire bill within a set time period: six months or two years, for example
- This time period is often negotiable
- Ask for ***interest-free*** payment plans
- Only agree to a payment plan that will be affordable ***every*** month
- Get written agreements for payment plans from providers
    - ***Caution:*** you can be sent to collections if you are paying every month but do not have a payment plan agreement
- Request monthly statements that record payments and the remaining balance

Summary of negotiation tips

- Ask for written copies of your provider's charity care and financial assistance policies and applications
- Speak with a Manager of Credit and Collections or Manager of Patient Accounts
- Get an interest-free payment plan that you can afford every month
- Build relationships with billing managers
- With hospitals, call attention to the American Hospital Association (AHA) guidelines when asking about charity care, financial assistance, and bill discounts
- Do not be afraid to offer a negotiated price and pay off the discounted amount in full, if possible

Suggested language to use when negotiating payment plans with a provider

"I want to pay my bills, but I don't have the money to pay them all at once."

"Please send me monthly statements showing my payments and remaining account balance."

*"May I please set up an **interest-free** payment plan?"*

"Please send me written confirmation about this payment plan."

"I can pay $_____ per month. Can we agree to that amount?"

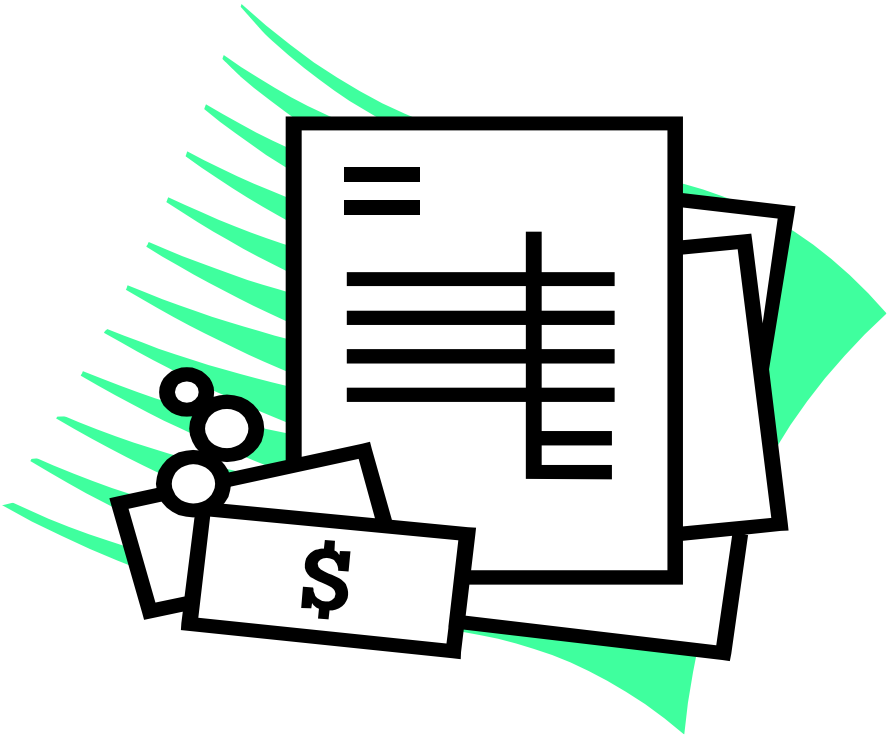
THE ACCESS PROJECT

April 2008

YOUR FIRST STEPS IN DEALING WITH MEDICAL BILLS

Includes information on:

- The Importance of Public Programs
- Charity Care
- Negotiating and Paying Medical Bills



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Public Programs

Many people are eligible for public health programs but do not know it. It is common for people to realize they are not eligible for Medicaid, however, they may not be aware of other programs for which they might qualify. It is always worthwhile to apply, or apply again if time has passed—minimum income levels for eligibility rise every year, so if you were on the cusp last time, you may now be eligible. Some hospitals may require an official recent denial from a public program, particularly Medicaid, to qualify for the hospital-based charity care or financial assistance program.

Many people don't know that they're eligible for public programs such as Medicaid

Some public programs pay retroactively for health care that you already received—even care that you're getting billed for—but there is always a time limit for coverage of past bills. That is why it is important to apply for public coverage programs before you need medical care, or as soon as you can after getting treatment. Some public programs may only cover care provided by certain doctors, clinics and hospitals.

Some public programs pay for past medical bills, but there's always a time limit. Apply as soon as possible!

Charity Care

Many hospitals offer charity care to uninsured and underinsured patients who are unable to afford part or all of their medical bills. Other medical providers—ambulance companies and doctors' groups, laboratories and so on—may also offer charity care or financial assistance to their patients. An important step in resolving medical bills is to ask medical providers about their charity care or financial assistance policies. Ask the provider billing office for written copies of the charity care policy and application.

Many medical providers offer lower cost care or free care to uninsured or underinsured patients who can't afford their medical bills.

Non-profit hospitals receive tax benefits due to their non-profit status and, therefore, are required to provide community benefits. Some non-profit hospitals have come under scrutiny from advocacy groups and the government for not providing enough community benefits, particularly charity care.

In 2003, the American Hospital Association released its "Guidelines for Billing and Collections Practices." More than 4,200 non-profit and for-profit have confirmed their commitment to uphold these guidelines, which include offering charity care and financial assistance to patients who cannot afford their bills.

Call up your medical providers and speak with a billing manager (for example, the Manager of Patient Accounts). Ask this person about applying for charity care.

Even if your hospital has signed onto the AHA Guidelines, you may still have to ask a billing manager about the charity care policies.

The "Guidelines" state that hospitals should:

- *Respond promptly to patients' questions about their bills and to requests for financial assistance.*
- *Use a billing process that is clear, concise, correct and patient friendly.*
- *Ensure that staff members who work closely with patients are educated about hospital billing, financial assistance and collection policies and practices.*
- *Make available for review by the public specific information in a meaningful format about what they charge for services.*
- *Make available to the public information on hospital-based charity care policies and other known programs of financial assistance.*
- *Have understandable, written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs.*

—Pages 2-3, AHA Guidelines

For a copy of the Guidelines and a list of the hospitals that have confirmed their commitment, visit http://www.aha.org and click on "billings and collections" under the "issues" tab.

If you have a hospital bill, use the American Hospital Association (AHA) Guidelines to ask about charity care and financial assistance programs.

Negotiating Medical Bills

Even if individuals or families are not eligible for charity care, they can usually negotiate to lower their health care expenses. The fact is that different people who receive ***the exact same medical services are often expected to pay different prices*** depending on whether or not they have insurance and, if so, what insurance they have. Insurance companies negotiate "discounted" prices for their members.

Medical bills are negotiable!
Call the Manager of Patient Accounts in your medical provider's billing office and ask for a discount.

Uninsured people do not have an insurance company negotiating on their behalf, so they are expected to pay much higher rates (sometimes called the "sticker price") for the same care that insurance companies get at a discounted price. Uninsured people are often those who can least afford health care, yet they face the highest health care costs.

Insured people whose insurance does not cover certain services will be charged the sticker price—as if they were uninsured—for "uncovered services."

There is often ample room to negotiate medical bills. Both uninsured and insured people should not hesitate to call their medical providers and ask for bill discounts and payment plans.

Deal with medical bills as soon as possible, even if you can't afford to pay them all at once—you may be eligible for a public program, charity care, or an affordable payment plan.

Paying Medical Bills

If you have a medical bill that is too expensive to pay off all at once, what can you do?

Ask the medical provider for an interest-free payment plan. Whether or not you receive a bill discount, health providers should offer you a payment plan. You do not have to accept the first plan that the billing manager offers you. Decide for yourself what is actually affordable, and bargain from there. Use your most recent pay stubs, your tax return from last year, and any other financial information to back up your case. Do not agree to a payment plan that you cannot afford!

Do not agree to a payment plan that you cannot afford.

What can happen to people who put off or delay paying medical bills?

The longer you wait to deal with medical bills, the more difficult they will be to clear up. Ask for a bill discount and get on an affordable payment plan right away.

Hospitals and other medical providers can, and often do, send unpaid bills to collections agencies. Many people report feeling disrespected and even harassed by agencies that aggressively pursue payment. Some collections agencies report to credit bureaus and may charge interest and fees on unpaid medical bills, where many medical providers do not. Ask your providers to send you a written copy of their Credit and Collections Policies.

Can unpaid medical bills have other negative consequences?

Unpaid medical bills can end up on one's credit report. Ruined credit can prevent people from accessing car or mortgage loans, credit cards, or other forms of credit. Even one's ability to get student loans or small business loans with low interest rates may be affected. Some employers look at credit reports before hiring, therefore bad credit may hurt one's chances at getting a job. Poor credit is one of the main road blocks preventing individuals and families from developing assets and bettering themselves economically. When a person's credit is ruined, the effects are long-term. Negative marks on a person's credit report can remain there for up to seven years.

Don't ignore medical bills!

Beyond ruining people's credit, some medical providers—or the collections agencies they use to collect bills—may file lawsuits or use other tactics to exact payment. In some cases, these agencies put liens on people's property, attach bank accounts, or sue them in court. Although these consequences are less common than effects on credit, some medical providers do take extreme measures.

If medical bills are unaffordable, is there anything that you can do to avoid these consequences?

People can avoid these consequences by dealing with their bills immediately and by working directly with the billing office or business office of their medical providers.

Medical Debt Resolution Intake Form

Date:_____

CLIENT INFORMATION

Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: (home):_____ (cell):_____ (work):_____

E-mail:_____ Best time to contact: _____

Gender:____ Ethnicity: _____ Date of birth:_____

Profession/employer:_____

Household size:_____ Family income: $_____ per ☐week ☐month ☐year

Type and name of insurance *(when debt incurred)*: _____

How did you learn about The Access Project: _____

PRIMARY CONTACT/ADVOCATE

Primary contact/advocate name: _____ Relationship to Debtor:_____

Home phone:_____ Work phone:_____ E-mail:_____

STORY DETAILS

1) What was the medical situation that made you seek care (please provide timeframe)?

_____

_____

_____

2) Please list the hospitals, doctors, ambulance companies, or other medical providers to whom you owe money *(use back of form if more room is needed)*:

Provider:_____ Amount Owed:$_____

Provider:_____ Amount Owed:$_____

Provider:_____ Amount Owed:$_____

Provider:_____ Amount Owed:$_____

Provider:_____ Amount Owed:$_____

TOTAL MEDICAL DEBT: $_____

3) Are any of your bills now with Collections Agencies (use back of form if more room is needed):

Agency:_____ Amount Owed:$_____

Agency:_____ Amount Owed:$_____

4) Have you taken any steps to deal with these medical bills?(i.e. calling insurance co. or doctor's office)?

5) What consequences have you faced due to your medical debt (financial, access to care, psychological, health, employment-related)?

6) Have you *recently* applied to any public programs? Which programs? What was the result?

7) What are the characteristics of the public program/insurance (for example, are there costs associated with it)?

8) Please provide any additional relevant details about your story below:

Action Plan Worksheet I: **Gathering Information**

This sheet should be used as a guide when working a client's case. All of these materials do not need to be gathered in every case. The client may have already received some of these materials in the mail. They will have to make phone calls or arrange meetings to collect the rest of this information.

CLIENT INFORMATION Outreach worker: _____ Date: _____

Name: _____

Phone: _____ Email: _____

FROM CLIENTS:

- ☐ Credit report, if clients think that medical bills may be hurting their credit
  - Access credit reports electronically through www.annualcreditreport.com or by calling the Credit Bureaus directly
- ☐ Materials they already received in the mail, such as medical bills, collections notices, letters from state agencies, etc.

Notes:

FROM PROVIDERS:

- ☐ Itemized bills
- ☐ Patient medical records
  - Only if the client thinks there was a billing error; providers can charge copying fees
- ☐ Charity care or financial assistance or policies and applications
- ☐ Communication letters sent by providers

Notes:

FROM COLLECTIONS AGENCIES:

- ☐ Collections notices
- ☐ Communication letters sent by collections agencies

Notes:

FROM PUBLIC PROGRAMS:

- ☐ Applications for public coverage programs
- ☐ Determination letters from state agencies
- ☐ Other notices (i.e. re-determination letters, changes in eligibility, etc.)
- ☐ Public program applications

Notes:

FROM PRIVATE INSURANCE COMPANY:

- ☐ Summary of insurance benefits or insurance policy
- ☐ Explanation of Benefits forms (EOBs) (they read: "This is not a bill")
- ☐ Communication letters from insurance company and appeal documentation

Notes:

Action Plan Worksheet II: **Steps to Take**

CLIENT INFORMATION Outreach worker: _____ Date: _____

Name: _____

Phone: _____ Email: _____

ACTION PLAN

Step 1:

Step 2:

Step 3:

Step 4:

Step 5:

Action plan will be completed by (due date): _____/_____/_____

Action Plan Worksheet III: **Taking Action on Your Case**
Guide to Making Effective Phone Calls

CLIENT INFORMATION Outreach worker: _____ Date: _____

Name: _____

Phone: _____ Email: _____

Name of institution: _____

(For example: Swedish Covenant Hospital, NCO Collections, Blue Cross Blue Shield, Legal Assistance Foundation of Metropolitan Chicago, etc.)

Type of institution: _____ **Phone number**: _____

(For example: hospital, insurance company, doctor's office, collections agency, advocacy group, etc.)

WHO DID YOU SPEAK WITH?

Name: _____ Job title: _____

Direct phone line: _____ Email: _____

What questions did you ask or what information did you share with this contact person?

_____

_____

_____

How did they answer your questions? Did they say anything else?

_____

_____

_____

Did you ask them to send anything in the mail? What did you ask for? What will they send you?

_____

_____

_____

Who else do you need to speak with in this institution? *(For example: supervisor, financial counselor, Manager of Patient Accounts, Chief Financial Officer, attorney, etc.):*

_____

_____

HIPAA-COMPLIANT PHI RELEASE FORM: AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, authorize the disclosure of my protected health information[1] as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization that I authorize to receive my protected health information is not subject to federal and state health information privacy laws,[2] subsequent disclosure by such person(s) or organization may not be protected by those laws.

1. I authorize the following person(s) and/or organization to **disclose** my protected health information (as specified in Paragraph 3 below):

Name (s): _____

Organization: _____

Address:_____

2. I authorize the following person(s) and/or organization to **receive** my protected health information, as disclosed by the person(s) and/or organization named in Paragraph 1.

Name(s): _____

Organization: _____

Address: _____

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):

_____Information relative to coverage and billing for health services._____

Please complete page 2…

THIS AUTHORIZATION IS INTENDED TO ALLOW **ORAL COMMUNICATION** BETWEEN THE COVERED ENTITY (PARAGRAPH 1) AND THE AUTHORIZED RECIPIENT (PARAGRAPH 2) REGARDING THE PROTECTED HEALTH INFORMATION OF THE INDIVIDUAL SIGNING THIS FORM. THE AUTHORIZED RECIPIENT IS **NOT** REQUESTING COPIES OF MEDICAL RECORDS AT THIS TIME.

4. Specific description of the purpose for each use or disclosure (or write "At my request" in this space):

At my request.

5. I understand that I may revoke this authorization at any time by sending a signed and dated letter to the person(s) or organization named in paragraph 1, except to the extent that the person(s) or organization named above has (have) already taken action in reliance on this authorization.

6. If I do not sign this form or if I later revoke my authorization, it will not affect the benefits or services for which I am eligible or that I receive from the person(s) or organization named in paragraph 1.

7. This authorization expires on _____

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____ _____
Signature Date

Name (Printed): _____

Address: _____

Telephone: _____ Social Security No. or Date of Birth: _____

_____
Relationship or Authority of Personal Representative (if applicable)

[1] Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must identify the individual or provide a reasonable basis to believe that the information could be used to identify the individual. 45 C.F.R. 160.103.

[2] Federal health information privacy laws apply to health plans, health care providers, and health care clearinghouses. 45 C.F.R. 160.103 (definition of "covered entity")

WORKING A CASE

Screen for Medical Debt

An effective and consistent screening protocol is essential for any group that is helping members or clients to resolve their medical debt.

Determine whether members or clients have medical debt by including screening questions during the intake process.

Some organizations may use a standardized intake form for every client. If so, it will be crucial to add a medical debt question to the intake form, other verbal scripts, and intake protocols. It will also be important to train intake staff to identify potential medical debt cases.

Key Medical Debt Screening Questions:

- Do you or any family member in your household currently owe money or have outstanding debt (loans or credit card) for medical bills?
- Are you or any family members currently paying off medical bills over time?
- Has a collections agency recently contacted you about a medical bill?
- Do you have any medical bills on your credit report?
- Estimate the total amount of your medical debt $_____

Once you have determined that a client or member has medical debt, refer this person to a staff member who is trained in medical debt resolution skills.

WORKING A CASE

Gather Case Information

Use the Intake Form and the Client Reporting Form-Medical Debt Worksheet to collect case information. Determine what information is missing and recommend steps to collect this information.

Before providing assistance to resolve medical debt, it is important to gather some basic case information. Contact information is necessary so you can contact clients at a later date to assess outcomes or provide additional support. Names of creditors, original providers, dates of services, and amounts of debt are crucial to developing customized and effective debt resolution action plans. Information about consequences, demographics, and medical causes for getting care may help to identify patterns of issues or problems across cases.

Key Case Information To Gather:

- Contact information
- Demographic information
- Medical debt information
  - Insurance status at the time of medical services
  - Names of original medical providers, names of current creditors
  - Amounts of debt, dates of medical services
  - Description of medical situations
  - Consequences of medical debt
  - Actions already taken by client

Work with clients to identify any crucial information that may be missing. For instance, a client may not know the names of medical creditors, the dates of services, or the amount they owe. Clients may be able to collect this information by gathering all of the relevant documents sent to them by insurance companies, public programs, and medical providers, or by calling these institutions to request more information.

TIP

Complete case information is not usually necessary to begin developing a medical debt resolution action plan. In fact, gathering additional information is often a key component of an action plan.

WORKING A CASE

Craft An Action Plan

While individual medical debt cases may have an infinite number of variations, most cases can be resolved using the following four strategies:

1. **Private insurance advocacy**
2. **Applying to public programs**
3. **Applying to a medical provider's charity care and financial assistance programs**
4. **Negotiating a payment arrangement**

These strategies are listed in the order that they should be considered for each client.

TIP
Multiple action steps should be pursued simultaneously.

KEY QUESTION:

- Did the client have private health insurance when s/he received the medical services that resulted in debt?
  - If so, begin at step one.
  - If the client was uninsured, skip step one and begin at step two.

Necessary step for all cases: Reach out to medical providers to deal with bills as soon as possible! Even if medical bills seem unaffordable, it is crucial to deal with them right away to avoid collections.

There are a variety of public and private programs that may be able to help clients to pay for unaffordable medical bills. Moreover, private insurance does not always pay what it should. It is important to leverage all available resources to deal with medical bills.

Contacting the medical provider through a written letter or telephone call is a necessary preliminary step in the medical debt resolution process. Ignoring medical bills will rarely make them go away. Unpaid bills will almost always end up with a collection agency, which can be much more difficult to deal with than a medical provider's billing office. Plus, medical bills in collections are often reported to credit bureaus, which can hurt a person's credit.

Steps for Resolving Medical Bills-Overview

Step One: *Ensure full and appropriate payment by private insurers*

Determine why clients owe medical debt despite health insurance coverage. Help clients to resubmit insurance information to providers when appropriate. Support clients to appeal claims that were denied by insurers.

There are a variety of reasons why privately insured people might owe out-of-pocket medical costs. For instance, a provider may not have a patient's correct insurance information, which can be resolved by providing the appropriate information. Additionally, almost all insurance plans include some form of cost-sharing through deductibles, co-payments, co-insurance, and coverage caps, which are the policy-holder's responsibility. Furthermore, insurance polices always exclude certain medical services from coverage under the plan and many limit coverage to particular "in-network" medical providers. Although many out-of-pocket costs are legitimate, insurers may deny payment for medical claims in error. Insurers can also make mistakes in how they categorize and code expenses or apply cost-sharing. Clients can redress denied claims and insurer errors through exercising their private insurance appeal rights.

For more information: See section on Private Insurance Advocacy.

Step Two: *Apply to Public Programs*

Both uninsured and privately insured clients may be eligible for public programs that can pay for past medical bills.

Applying to public programs, such as Medicaid, is a strategy to resolve medical debt because some programs are able to pay for past medical bills. Some programs may be able to pay for past bills regardless of a client's health insurance status. The types of available programs and eligibility criteria vary widely across different states.

For more information: See section on Public Programs.

NOTE:
Clients should never wait to apply for public programs. There is always a time limit on retroactive payment by public programs, so it is crucial to apply as soon as possible after receiving medical services.

TIP
Privately insured individuals who are pursuing an insurance appeal should still apply for public programs in a timely manner.

Steps for Resolving Medical Bills-Overview (con't)

Step Three: *Apply to medical providers' charity care and financial assistance programs*
Medical providers can offer charity care and financial assistance to their patients who are struggling with the costs of care.

Medical providers, especially non-profit hospitals, frequently have private programs to help their patients to cover past medical expenses. These programs are institution-specific; therefore eligibility criteria for charity care can vary widely across different providers. In many cases, both uninsured and underinsured patients may qualify.

For more information: See section on Charity Care and Financial Assistance.

Step Four: *Negotiate an affordable payment arrangement*
Patients can work directly with their medical providers to negotiate discounts, monthly payment plans, and other payment arrangements.

Even if people are not eligible for charity care, they may still be able to negotiate with medical providers to get discounts and affordable payment arrangements. People who receive the exact same medical services are often expected to pay different prices depending on whether or not they have insurance and, if so, what insurance they have. Providers rarely have a fixed payment amount for any particular service; therefore, there is often ample room to negotiate medical bills.

For more information: See section on Negotiating Medical Bills.

TIP
Both uninsured and insured people should not hesitate to call or write their medical providers to ask for bill discounts and payment plans.

PRIVATE INSURANCE ADVOCACY

Understanding Health Insurance: What's in a Health Plan?

There are a variety of reasons why an insured individual may owe medical bills despite having health insurance coverage, from "normal" cost sharing provisions (i.e. deductibles, co-payments, and co-insurance) to insurer denial of medical claims. Understanding health care coverage can be challenging, especially since the private insurance system is overlaid on an equally complex medical provider billing system. This section offers guidance to help clients untangle why they owe medical debt under their insurance plans and outlines strategies to resolve some of these problems.

Private insurance policies, also called "certificates of coverage," contain very specific criteria about what will—and what will not—be covered under the plan, i.e. covered benefits and exclusions. Insurance policies also include detailed information about out-of-pocket costs such as deductibles, co-payments, co-insurance, and coverage caps.

DEFINITIONS

A **Health Insurance Policy** (also called "**certificate of coverage**") provides full documentation of coverage, exclusions, and cost-sharing under an insurance plan. Members can obtain an insurance policy by contacting the insurer directly. Some employer human resource departments may also have the plan on file. An insurance policy is not a "summary of benefits."

An insurance plan's "**summary of benefits**" lists the basic information about the plan. Summaries usually include contact information for the plan, basic information about the network and patient responsibilities, as well as itemization of the plan's out-of-pocket costs (i.e. deductibles, co-payments, co-insurance, and caps). Summaries do not include full and complete information about the plan.

Health insurance **covered benefits** are medical services, supplies, treatments, procedures, or other claims that should be reimbursed by the insurer.

Health insurance coverage **exclusions** are medical services, supplies, treatments, procedures, or other claims that are not covered by the insurer. Exclusions are also called "uncovered services." A full list of exclusions can be found in the insurance policy, although sometimes excluded benefits are listed in plan summaries.

A **deductible** is the amount that people have to pay before their insurance begins to pay for care.

Co-payments are the up-front costs that people owe every time that they visit the doctor or hospital, often $25-$50.

Co-insurance is the percentage of charges (after the co-payment and deductible) that people owe to the medical provider for the services that they received. An 80/20 coinsurance rate means that one owes 20% of the charges, usually after the insurer's discount has been applied. The plan pays the remaining 80%.

Coverage caps limit the amount that the insurance pays for care. Once people reach their coverage caps, they become responsible for any additional medical bills as if they were uninsured. Some caps may only be applied to particular kinds of medical costs (for example, prescription medications may have a separate cap from the rest of the plan).

Out-of-pocket (OOP) limits (also called "**OOP maximums**") are the total amount of out-of-pocket costs that an individual is responsible for under the plan's covered benefits. OOP limits are most common under plans that have co-insurance. Payment for uncovered services are not typically included under these limits, so a person may end up paying more than the limit amount if they had no coverage for particular services.

Understanding Health Insurance: What's an Explanation of Benefits form (EOB)?

Explanation of Benefits forms (EOBs) are notices sent by an insurance company to document medical services, any denied claims (and a reason for denial), insurer payments, individual out-of-pocket costs, benefit limits, and insurance discounts. EOBs are always sent directly to an individual by the insurance company and say "This Is Not A Bill." There is no standard format for EOBs, but they are required to contain the basic information listed above.

EOBs can be difficult to interpret. It is very important that people learn how to read the EOB forms that are sent by their own insurance companies. EOBs can be a very useful tool to identify insurer errors and any denied claims that should be appealed.

*See "**A Greater Understanding…Interpreting your Explanation of Benefits (EOB)**," from the Patient Advocate Foundation, Publication No. 3 7/2007, included in this section.*

Review Materials for Accuracy

- Collect copies of any outstanding medical bills. See "Negotiating Medical Bills" section for help with getting and understanding medical bills.
- Get copy of a full insurance policy directly from the insurance company or, if relevant, from the human resources department of an employer.
- Review the insurance policy to understand covered benefits, exclusions, and out-of-pocket costs.
- Collect all EOBs regarding the services for which clients owe medical debt.
- Compare the EOBs to the medical bills to identify which EOBs correspond to which medical bills
  - EOBs and medical bills should correspond directly. Every charge on a medical bill should relate to specific line items on an EOB. Sometimes EOBs will lump together charges from a specific provider by the dates-of-service.
  - An EOB may list an amount owed as outstanding even if it has already been paid to the provider. This happens commonly with co-payments.
  - Make sure that co-payments, deductibles, and co-insurance amounts are listed in the appropriate columns or sections of the EOBs.
- Review EOBs, medical bills, and the client's insurance policy to ensure that co-payments, co-insurance, deductibles, and coverage caps were applied properly (i.e. according to the insurance policy).
- Review EOBs for any coverage denials.
  - If there is a coverage denial, what is the reason for denial?
  - The insurer will always list a code next to a denied claim.
  - The meaning of the code is usually listed somewhere on the EOB, often underneath the medical claims summary.
  - Definitions of these codes may also be listed in the insurance policy.
  - Insurers pay nothing on denied claims—the patient will not even receive a network discount.

NOTE:
If an EOB has not yet been issued for a particular medical claim, it is possible that the claim is still being processed by the insurance company.

PRIVATE INSURANCE ADVOCACY

Addressing Unaffordable Out-of-Pocket Costs

Advocating directly with an insurer is usually not the best approach when clients owe medical bills due to deductibles, co-payments, co-insurance, or coverage caps. It is unlikely that filing an appeal will convince the insurance company to cover out-of-pocket costs that are outlined in the policy. These expenses are best addressed through applying to public programs, seeking charity care, and negotiating payment arrangements directly with providers (see the sections on "Public Programs", "Charity Care", and "Negotiating with Medical Providers.")

However, there are instances where an insurer may have miscalculated a patient's out-of-pocket responsibility or applied charges to a deductible or co-insurance that should have been covered. Evidence of such errors may be found in a patient's Explanation of Benefits forms (EOBs) and medical bills. In the case of an insurer error, it is important to make an appeal (see the information on making insurance appeals later in this section).

Insurance Denials

Denied claims are those that an insurer, upon initial review, decided were not eligible for payment. They are considered to be "uncovered services" where the patient will owe 100% of the medical charges. Coverage denials should be clearly presented on the EOB.

Common reasons for denial and strategies for resolution:

1) No insurance coverage on the dates of medical service. Insurance companies generally deny medical claims for non-members. It is highly unusual that a private insurance plan will cover medical claims for someone who was not a member on the dates of receiving medical services. This kind of denial occurs most frequently to new enrollees, or to people who were suddenly dropped from coverage.

Strategy:

- Contact the insurance company or employer human resources department to verify a person's dates of coverage under the plan.
- Determine whether the denial was warranted based on the confirmed coverage dates.
  - If so, there is little recourse with the insurer, so the client should pursue other means of resolving the bills (i.e. negotiations, charity care, public programs.)
  - If not, the client should submit proof of coverage to the provider and insurer to re-bill the medical claims.
  - If necessary, send a written appeal to the insurance company to dispute the coverage denial. Include proof of coverage for the service dates.

2) Medical provider billed wrong insurance carrier. If a person changes insurance carriers or goes uninsured for a period of time, it is possible that a provider may send bills for new care to an old insurance carrier. As described above, insurance companies rarely cover bills for people beyond their coverage dates. Incorrect billing can also happen if a person changes plans under the same insurance carrier.

Strategy:

- If a client has coverage under a new insurance plan, submit the new member number to the medical provider.
  - The provider should bill the new carrier for the medical claims.
  - If the client was a subscriber on the date of medical service, then the insurance company should cover some or all of the claims as dictated under the policy.

3) Insurer deemed the medical care to be an "uncovered service," "not medically necessary," or "out-of-network." These are some of the most common reasons for denying medical claims.

Strategy:

- Identify denied claims by reviewing the client's EOBs
  - See details above.
- Compare the information in the EOB to the insurance policy and medical bills to determine whether or not the denial was justified.
  - If the specific service was listed as an excluded benefit, the client may have little recourse.
  - If the reason for denial is ambiguous, however, then it is worth filing an appeal:
    - o If the claim was denied based on "medical necessity," it is important to procure written support from doctors that the care was, in fact, necessary.
    - o If the claim was due to a network issue, it will be crucial to gather more information about the insurance company's network to discern whether the denial was in error. Patients can call their insurance company directly to get a list of in-network providers.
    - o If the denial was due to an uncovered service, look at the insurance policy to determine whether that care should have actually been covered.
  - See below for more information about filing appeals.
  - Seek legal assistance for help with an appeal if necessary.

DEFINITIONS

"**Medically necessary**" is a term used by insurers to describe medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice.

An **insurance network** comprises the array of medical providers—including doctors, hospitals, and ambulance companies—that agree to provide care to members of a plan under its guidelines and restrictions. Many insurance plans will only cover medical services offered by the medical providers in the plan's network (i.e. "in-network"). Some plans may cover out-of-network care but require clients to pay higher rates for providers that are "out-of-network."

"**Uncovered services**" are medical claims for which insurance companies will provide no reimbursement. Some uncovered services may be categorically excluded under the insurance policy, while others may be incurred after a benefit cap or limit has been exhausted.

NOTE:
Some in-network hospitals have out-of-network doctors groups that work within them. It is important to consult the insurance company to determine if the doctors groups, labs, and other in-hospital providers are in-network. Clients should not just take a doctor's word for it or assume that all the providers will be covered.

PRIVATE INSURANCE ADVOCACY

Filing an Appeal (also called the "grievance process")

State and federal law gives people the right to appeal denied health insurance claims. Insurers are required by law to offer their subscribers transparent information about appeal rights and processes. Information about the appeal or grievance procedure will be included in the client's insurance policy. Some states also require insurers to include this information on EOBs. Every insurance company has a slightly different appeal process.

In most cases, insurers will ask members to write an appeal letter or grievance letter. While specific procedures may vary, in general, it will be important to include the following information in an appeal letter:

- Member's name and ID number
- Description of the problem, including all relevant dates
- Explanation of why the claim should have been covered
- Names of health care providers or others involved
- Details of attempt(s) to resolve the case
- Daytime phone number and other contact information where the patient can be reached

There are usually multiple levels of appeals. The first stage of the appeal process always involves filing an appeal directly with the insurer. If a first appeal is not successful in overturning the insurer's determination, people can often file an additional appeal, often called a "second level appeal." A second level appeal will often be made directly to the insurance company, although the process may vary by insurer (see sample letter, "***Appeal to Insurance Company–Second Level***"). Consult the client's insurance policy to determine the correct appeals process.

NOTE:
If the client does not hear back from the insurer about the first appeal within thirty days, it may be useful to send an unsolicited second level appeal letter.

External Review

Effective July 1, 2010, the Health Carrier External Review Act (the "Act;" P.A. 96-857) grants all Illinois residents with health insurance the right to an external, independent review of denied health insurance claims.

Whether you submit a claim after receiving medical treatment or attempt to pre-certify a treatment recommended by your doctor, health insurance companies and HMOs will review the claim or pre-certification request to determine if the treatment is "medically necessary." If the insurance company or HMO determines the treatment is not medically necessary, it will deny the pre-certification request, or deny or reduce payment for the claim.

External reviews will be conducted by unbiased and qualified physicians, selected by nationally-accredited independent review organizations approved by the Department of Insurance. The entire cost of an external review will be paid for by the health insurance company or HMO.

Which health insurance policies must provide for an external independent review?
All fully insured individual and group major medical health insurance policies and HMO contracts must provide for an external independent review in accordance with the Health Carrier External Review Act.

The Health Carrier External Review Act does not apply to:

- Health insurance policies that provide coverage only for a specified disease (for example, a cancer-only policy); specified accident or accident-only coverage; credit; dental; disability income; hospital indemnity; long-term care insurance; vision; or other limited supplemental benefits;
- Coverage through Medicare, Medicaid, or the Federal Employees Health Benefits Program;
- Self-insured employer plans;
- Self-insured health and welfare plans, such as union plans;
- Insurance policies or trusts issued in other states.
  For HMOs, the Act does apply to contracts written outside of Illinois, if the HMO member is an Illinois resident and the HMO has established a provider network in Illinois. To determine if your HMO plan must comply with the Act, contact your HMO or check your certificate of coverage.

For More Information: Call the Department of Insurance Consumer Services Section at (312) 814-2427 or our Office of Consumer Health Insurance toll free at (877) 527-9431 or visit us on our website at http://insurance.illinois.gov/HealthInsurance/externalreview.pdf.

Assistance Provided through the IL Attorney General's Health Care Bureau
The Attorney General's Health Care Bureau was created to assist the consumers of Illinois with these problems related to confusion and difficulty obtaining the care and benefits to which they are entitled. Health Care Bureau intake workers accept consumer complaints either verbally or in writing, and then open a mediation file or refer the consumer to the appropriate agency for assistance.

The Health Care Bureau offers a successful mediation program to help consumers resolve their complaints. Mediators are trained in alternative dispute resolution and work directly by phone, fax, and letter with all parties involved in the dispute. Once a mediation file is opened, the mediator contacts the consumer to collect information and contacts the provider and/or insurance company to settle the dispute.

For more information on the Bureau, or to access a link to file a complaint, visit the site through this link http://illinoisattorneygeneral.gov/consumers/healthcare.html.

See Office of Illinois Attorney Generals's brochure "Appeals and Independent Reviews Your Rights Under the Illinois Managed Care Reform and Patient Rights Act" at http://illinoisattorneygeneral.gov/consumers/appealsreviews0404.pdf

GIVE
"A PROMISE OF HOPE"

Donate a Clever
"Promise of Hope"

- Appreciated stock that you have owned for at least a year.
- Frequent-flier miles and similar perks from credit cards or other rebate programs.
- A gift for a child from a child - help your children or grandchildren pick out a stuffed animal or toy to give to a child in the hospital.
- Time – Volunteer for Patient Advocate Foundation.

Become a Partner in Progress with a Monetary "Promise of Hope"

- Donate a tax-deductible contribution In Memory of or In Honor of someone special.
- Encourage the company or organization you are employed with to match your contribution.
- Consider making a donation even if you don't have cash, using your VISA or MasterCard.
- Remember Patient Advocate Foundation in your estate.

Patient Advocate Foundation
700 Thimble Shoals Blvd., Suite 200
Newport News, VA 23606
Toll Free: 1-800-532-5274
Fax: (757) 873-8999
Email: info@patientadvocate.org
Website: www.patientadvocate.org

Publication No. 3, 7/2007

A Greater Understanding

Interpreting Your Explanation of Benefits (EOB)

Patient Advocate Foundation

A Greater Understanding

Patient Advocate Foundation
MISSION STATEMENT

Patient Advocate Foundation is a national non-profit organization that serves as an active liaison between the patient and their insurer, employer and/or creditors to resolve insurance, job retention and/or debt crisis matters relative to their diagnosis through case managers, doctors and attorneys. Patient Advocate Foundation seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability.

Editors Note:

This is the third in the series "A Greater Understanding" brochures developed by the Patient Advocate Foundation. The information contained herein is in response to frequently asked questions (FAQ's) by patients. This brochure is intended to provide a general yet informative response to these inquires. Any incident, inquiry or issue may vary according to these specific facts and circumstances relating to the individual.

Patient Advocate Foundation
PUBLICATIONS

- ***The Managed Care Answer Guide***
  Available in English & Spanish
- ***The Patient Pal***
  Available in English & Spanish
- ***Your Guide to the Appeal Process***
  Available in English & Spanish
- ***First My Illness…Now Job Discrimination: Steps to Resolution***
  Available in English & Spanish
- ***Your Guide to the Disability Process***
  Available in English & Spanish
- ***The National Financial Resource Guide for Patients: A State-By-State Directory***
- ***Too Young To Be Ill...***
  A Practical Survival Guide for Caregivers of Children and Young Adults
- ***Guide to Health Savings Accounts***
- ***Promoting a Healthier African American community***
- ***Promoting a Healthier American Indian and Alaska Native Community***
- ***"A Greater Understanding" series***
  A series of pamphlets written to provide answers to the most frequently asked questions regarding health care.

If you would like further information about any of these publications, please contact our office or visit our website: www.patientadvocate.org

Most of us have seen an "Explanation of Benefits" or EOB, but what does it mean?

After you've visited a doctor, clinic, or hospital, an EOB from the insurance administrator tells you and your provider what portion of the provider's charges are eligible for benefits under your insurance plan.

The EOB is the result of the ***claims process***. To better understand your EOB, let's look at the steps in the claims process.

- If your provider is part of a provider network, and you have an insurance plan using this network, the provider usually sends your bill to the network to have the network discount calculated. The network sends the claim to your insurance administrator.
- If your provider is not in a network, the provider may send the bill to you or your insurance company. If you're sent the bill, you will submit the claim to your insurance administrator.
- Your insurance administrator reviews the claim to determine your benefits. If another insurance company is involved, the insurance companies coordinate the benefits to determine which plan is responsible for the charges. Your health administrator sends you and your provider an EOB, and, when appropriate, your provider also receives a check. Your EOB may identify:
  - The patient and the service provided.
  - The amount charged by the provider.
  - The amount of the charges that *are covered* and *not covered* under your plan.
  - The amount paid to your provider.
  - The amount you're responsible for.

- **Remember that the EOB is not a bill**, but it explains what was covered by insurance. The provider may bill you separately for any charges you're responsible for.

Below is an example of an EOB. Each section of the EOB has a number shown in parenthesis that corresponds to the following explanations for each section.

(1) **Enrollee Name:** Identifies the policyholder. This is usually the name of the person who carries the insurance.
(2) **Patient:** Identifies the patient.
(3) **Patient #:** This serves as an identification number for the patient.
(4) **Provider Name:** Identifies the name of the doctor or hospital that is billing for the services. Verify services were actually rendered by the provider listed.
(5) **Claim #:** This is a number assigned to the claim by the insurance company to identify the claim in their computer system.
(6) **Date Processed:** Indicates the date on which the claim was processed.
(7) **Enrollee Address:** Indicates the address of the enrollee; this should be verified with each claim. A wrong address can cause problems in claims payment.
(8) **Date of Service:** Indicates the date of when the service was rendered.
(9) **Place of Service:** Indicates the location the service was rendered. This is important as some services are only covered in specific locations.
(10) **CPT Code:** This identifies the service performed. This code is universal and cites the payment allowances.
(11) **Charge Amount:** Amount charged by provider of service.
(12) **Allowed Amount:** Amount allowed for the service is determined by a preset schedule of "usual and customary" (UCR) charges. Amount is usually determined by geographic location of provider. For more information, please request the *Greater Understanding Series* on *UCR Charges.*
(13) **Not Covered:** Amount not included in the *allowed amount*; usually this is the amount deemed over the usual and customary allowance. In most incidences, the patient is responsible for the overage.
(14) **Reason Code:** This is an explanation of why a service was denied, or why an amount is not covered.*
(15) **Deductible:** This reflects the amount the patient must pay prior to having the benefits paid. Amounts that are *not covered* are not applied to the deductible. Generally, each patient will have his or own deductible to meet. Deductibles may be required for both participating and non-participating providers; refer to the schedule of benefits.
(16) **Co-Pay:** A minimal amount required from the patient when seeking services from a provider. Usually the patient is responsible for co-payments only at a participating provider.
(17) **Benefit Amount:** This is the percentage at which the *amount covered* will be paid. The percentage paid will be determined by the schedule of benefits. Generally, participating providers will be paid a higher level; non-participating providers will be paid a lower level.
(18) **Due from Patient:** This is the amount the patient is responsible for paying to the provider. This generally includes the co-pay amount, deductible and may or may not include the amount over the UCR. If the amount over the UCR is not included, the patient needs to verify if the provider of service will write the amount off. If the provider of service will not write the amount off, the patient is responsible.
(19) **Payment Amount:** This is the amount paid to the provider.
(20) **Customer Service:** This is the number used to contact the customer service for your insurance.

Your Health Insurance
P.O. Box 1999
Anytown, USA 12345

This is Not a Bill

(20) Customer Service 800-555-1212
(1) Enrollee: John Doe
(2) Patient: Jane Doe
(3) Patient #: 123-45-6789
(7) Enrollee Address: 555 Main Street
Hometown, USA 54321

(4) Provider Name: Mark Smith, M.D.
(5) Claim #: 99999999999
(6) Date Processed: 9/25/02

(8) Dates of Service		(9) Place of Service	(10) CPT Code	(11) Charge Amount	(12) Allowed Amount	(13) Not Covered	(14) Reason Code	(15) Deductible Amount	(16) Co-Pay	(17) Benefit Amount	(18) Due from Patient	(19) Payment Amount
8/9/02	8/9/02	3	99201	80.00	80.00				15.00		15.00	
8/9/02	8/9/02	3	10121-22	150.00		150.00	55			0.00	0.00	0.00
8/9/02	8/9/02	3	36415	20.00	10.00	10.00	44			80%	2.00	8.00
8/9/02	8/9/02	3	80050	40.00	10.00	30.00	44			80%	2.00	8.00

*These codes are explained in foot notes on the EOB.

Illinois Insurance Facts

Illinois Department of Insurance

Independent Review of Denied Health Insurance Claims

July 1, 2010

Note: This information was developed to provide consumers with general information and guidance about insurance coverage and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

Whether you submit a claim after receiving medical treatment or attempt to pre-certify a treatment recommended by your doctor, health insurance companies and HMOs will review the claim or pre-certification request to determine if the treatment is "medically necessary." If the insurance company or HMO determines the treatment is not medically necessary, it will deny the pre-certification request, or deny or reduce payment for the claim.

Effective beginning **July 1, 2010**, the Health Carrier External Review Act (the "Act;" P.A. 96-857) grants all Illinoisans with health insurance the right to an external, independent review of denied health insurance claims.

- External reviews will be conducted by unbiased and qualified physicians, selected by nationally-accredited independent review organizations approved by the Department of Insurance.
- The entire cost of an external review will be paid for by the health insurance company or HMO.

Which health insurance policies must provide for an external independent review?

All fully insured individual and group major medical health insurance policies and HMO contracts must provide for an external independent review in accordance with the Health Carrier External Review Act.

The Health Carrier External Review Act does not apply to:

- Health insurance policies that provide coverage *only for* a specified disease (for example, a cancer-only policy); specified accident or accident-only coverage; credit; dental; disability income; hospital indemnity; long-term care insurance; vision; or other limited supplemental benefits;
- Coverage through Medicare, Medicaid, or the Federal Employees Health Benefits Program;
- Self-insured employer plans;
- Self-insured health and welfare plans, such as union plans;
- Insurance policies or trusts issued in other states.
    - For HMOs, the Act does apply to contracts written outside of Illinois, if the HMO member is an Illinois resident and the HMO has established a provider network in Illinois. To determine if your HMO plan must comply with the Act, contact your HMO or check your certificate of coverage.

NOTE: The federal Patient Protection and Affordable Care Act (the "Affordable Care Act") requires all individual and group health plans—including self-insured plans—to provide appeals procedures similar to those required by the Health Carrier External Review Act. This requirement is effective for plan years beginning on or after **September 23, 2010**. If you receive coverage through a self-insured plan, please contact your employer for more information on when the appeals procedures required by the Affordable Care Act will be effective for your plan.

The Department of Insurance and the U.S. Department of Health and Human Services will provide guidance for self-insured employers on the appeals procedures required by the Affordable Care Act.

For more information on the Affordable Care Act, please visit the Department's Health Insurance Reform Information Center at: www.insurance.illinois.gov/HIRIC.

How do I request an external independent review?

Your health insurance company or HMO must provide you information about your right to request an external review, including an explanation of how to submit the request. This information must be included in your policy or certificate, membership booklet, and outline of coverage (or other similar document). In addition, beginning July 1, 2010, your insurance company or HMO must inform you in writing of your right to request an external review every time the company denies a pre-certification request or claim submitted by you or your doctor based on a determination as to the medical necessity of the recommended treatment.

Your insurance company or HMO will provide a form for you to submit a written request for an external review. In urgent cases (see below), you may also file a request over the telephone.

You must file your request for an external review within **four (4) months** after you receive notice from your insurance company or HMO that the treatment recommended or provided by your doctor has been denied. If you submit an internal appeal to your insurance company or HMO and your appeal is denied, you must file your request for an external review within 4 months after you receive notice that your appeal has been denied.

NOTE: An "authorized representative" may file a request for an external review on your behalf. An authorized representative must be: i) someone to whom you have given express written consent to represent you in an external review; ii) a person authorized by law to provide substituted consent for you; or iii) your health care provider, if you are unable to give consent.

Which requests are eligible for external independent review?

Once you submit a request for an external review, your insurance company or HMO has **five (5) business days** to determine if your request is eligible. In general, your request will be eligible for external review if:

1) You were covered by the insurance policy or HMO contract at the time the treatment was requested or provided;

2) The treatment is covered by your policy or contract, but your insurance company or HMO has determined the treatment does not meet its requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

3) You have first filed an internal appeal to your insurance company or HMO, and the company has upheld its decision to deny payment for the treatment in question;

   - In certain urgent cases, you may be eligible for an "expedited" external review even if you have not filed an internal appeal with your insurance company or HMO;

   - In addition, you may be eligible for an external review if you filed an internal appeal but have not received a decision from your insurance company or HMO within 15 days after the company receives all required information (in no case longer than 30 days after you first file the appeal), or within 48 hours if you have filed a request for an expedited internal appeal;

     NOTE: For more information about filing an internal appeal with your insurance company or HMO, please see the Department's fact sheet on Medical Necessity at www.insurance.illinois.gov/HealthInsurance/Medical_Necessity.asp.

4) If the treatment is considered "experimental" or "investigational" by the insurance company or HMO, your health care provider (who must be a licensed physician) has certified that other "standard" treatments are not appropriate for your condition due to one of several reasons;

5) You have provided all required information and forms.

If your insurance company or HMO determines that your request is ineligible for an external review, it must give you a written explanation of why your request is ineligible or incomplete within one (1) business day. You may appeal the company's determination by filing a complaint with the Department.

How will the independent reviewer make its decision?

1) Once your insurance company determines that your request is eligible for an external review, it has **five (5) business days** to assign a qualified Independent Review Organization ("IRO"), from a list of IROs approved by the Department of Insurance, to review your case.

   The IRO must assign a qualified clinical reviewer—a physician or other appropriate health care provider who is an expert in the treatment of your medical condition, with recent or current actual clinical experience treating patients with the same or similar condition and, for physicians, a current specialty certification appropriate to your condition—to review your case.

2) Within **five (5) business days** of assigning the IRO, your insurance company or HMO must submit to the IRO all the information the company used in making its decision to deny your treatment, including any information it may have received from you or your health care provider. You also have **five (5) business days**, from the date you receive notice from your insurance company or HMO that your request is eligible for an external review, to submit any additional information to the IRO. The IRO must maintain a 24-hour-a-day, 7-day-a-week system to receive and process such information.

3) In addition to the information provided by you and your insurance company or HMO, the IRO must consider information including: your relevant medical records, your provider's recommendation, and the most appropriate practice guidelines for your condition, which must include any applicable evidence-based standards.

   For external reviews involving experimental or investigational treatments, the IRO must also consider additional medical and scientific evidence to determine whether the treatment recommended by your provider is likely to be more beneficial to you than any other available "standard" treatment(s), and whether the adverse risks of the recommended treatment would be substantially increased compared to the available standard treatment(s).

4) After receiving all necessary information, the IRO has **five (5) calendar days** to provide written notice of its decision to you and your insurance company or HMO. If the IRO makes a decision reversing the original denial of treatment, your insurance company or HMO must immediately approve the coverage.

   The written notice from the IRO must include basic information about the external review, including the date the review was initiated and the time period during which it was conducted, a description of the documentation and evidence considered, and the principal reason for the decision, including any applicable evidence-based standards.

   For reviews involving experimental or investigational treatments, the notice must also include a description and analysis of all medical and scientific evidence considered, and the written opinion of the clinical reviewer as to whether the evidence demonstrates that the recommended treatment would be more beneficial to you than other available standard treatment(s), and whether the adverse risks of the recommended treatment would be substantially increased compared to the available standard treatment(s).

Can I appeal the decision of an independent reviewer?

Yes. You can appeal the decision of an IRO by filing a complaint with the Department. If the Department, in consultation with a licensed medical professional, finds that the IRO's decision was "arbitrary and capricious"—for example, if the decision entirely failed to consider an important aspect of your case—the Department can overturn the IRO's decision and require the insurance company or HMO to pay for the treatment in question.

If your insurance company or HMO appeals the Department's decision, the Department must assign a new IRO to reconsider your case. The new IRO must make its decision using all of the information described above.

NOTE: The decision of an IRO, and any subsequent appeal, does not prevent you from pursuing any other remedy available under federal or State law.

What if I have an urgent medical condition?

In certain urgent circumstances, you may have the right to an "expedited" external review. An expedited external review is similar to the standard external review described above, except that the review must be completed within **72 to 120 hours** after you file the request:

- Your insurance company or HMO must **immediately** determine whether your request is eligible for an expedited external review;
- Your insurance company or HMO must **immediately** assign a qualified IRO from the list of approved IROs as described above;
- Your insurance company or HMO must **immediately** submit all necessary information to the IRO, but in no case more than **24 hours** after assigning the IRO;
- The IRO must notify you and your insurance company or HMO of its decision "as expeditiously as [your] medical condition or circumstances requires," but in no event more than **two (2) business days** after the IRO receives all necessary information.

If you have <u>already filed an internal appeal</u> with your insurance company or HMO, and your appeal was denied (or if you have not received a decision within 48 hours), you may request an expedited external review—by telephone or in writing—if:

1) You have a medical condition in which the time it would take to complete a standard external review (15 business days + 5 calendar days, as described above) would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function;

2) The recommended treatment involves an admission, availability of care, continued stay, or health care service for which you have received emergency services but have not yet been released; or

3) For a treatment considered by your insurance company or HMO to be experimental or investigational, your health care provider certifies that the treatment would be significantly less effective if it is delayed.

If you have <u>not yet filed an internal appeal</u>, you may request an expedited external review—by telephone or in writing—if:

1) You have a medical condition in which the time it would take to complete an expedited internal appeal (48 hours) would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or

2) For a treatment considered by your insurance company or HMO to be experimental or investigational, your health care provider certifies that the treatment would be significantly less effective if it is delayed.

To be eligible for an expedited external review, your request must also meet the eligibility requirements of items (1), (2), and (4) described on pages 2-3 above.

NOTE: A request is not eligible for expedited external review if the request relates to a "retrospective" denial, or a case in which the insurance company or HMO has denied or reduced payment for a treatment <u>after</u> the treatment has already been provided.

How do I know that the independent reviewer assigned to my case is truly independent?

To be approved by the Department, an IRO must satisfy numerous requirements of the Health Carrier External Review Act designed to ensure that both the IRO and the clinical reviewer assigned to your case by the IRO are unbiased and free from conflicts of interest. For example:

- An IRO must establish and maintain written procedures to ensure the selection of "qualified and impartial" clinical reviewers, and to ensure that the IRO's assignment of a particular clinical reviewer is not made or controlled by either the person requesting the external review or the person's insurance company or HMO.
- An IRO may not own or control, be a subsidiary of, or in any way be owned, or controlled by, or exercise control with a health insurance company or HMO, any trade association of insurance companies or HMOs, or any trade association of health care providers.
- An IRO may not be assigned to review a specific case if the IRO or the clinical reviewer assigned by the IRO has any material professional, familial, or financial conflict of interest with:
    - the health insurance company or HMO;
    - any officer, director or management employee of the insurance company or HMO;
    - the person requesting the review (or the person's authorized representative, if applicable);
    - the health care provider, or the health care provider's medical group or independent practice association;
    - the facility at which the recommended treatment would be provided; or
    - the developer or manufacturer of the primary drug, device, procedure, or other therapy that is the subject of the external review.
- An IRO must establish and maintain written procedures to ensure it is unbiased.

An IRO must renew its approval with the Department every two years. The Department may revoke the approval of an IRO at any time if it finds the IRO is not satisfying the minimum requirements of the Act, including the conflict of interest standards described above.

For a current list of the IROs approved by the Department, please click here.

For More Information

Call the Department of Insurance Consumer Services Section at (312) 814-2427 or
our Office of Consumer Health Insurance toll free at (877) 527-9431
or visit us on our website at http://insurance.illinois.gov

LISA MADIGAN
ILLINOIS ATTORNEY GENERAL

Appeals and Independent Reviews Your Rights Under the Illinois Managed Care Reform and Patient Rights Act

The Managed Care Reform and Patient Rights Act provides Illinois consumers with more control of their health care by placing stricter requirements on HMOs, insurance companies, doctors, and other health care providers. The Act also gives consumers specific rights, including:

- **THE RIGHT TO APPEAL** service denial decisions made by their health care plan
- **THE RIGHT TO REQUEST AN EXTERNAL INDEPENDENT REVIEW** if an appeal for medical services is denied by their health care plan

The Act generally applies to state regulated managed care plans, including all state regulated HMOs. The Act does not *apply to indemnity health insurance policies, plans that offer only dental or vision coverage, Preferred Provider Administrators, ERISA plans, care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act, or not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999, that are affiliated with a union and that only extend coverage to union members and their dependents.*

THE RIGHT TO APPEAL

Who can appeal a denial of services by a health care plan?
After any denial of services, an appeal may be filed by the enrollee, the enrollee's designee or guardian, the enrollee's primary care physician, or the enrollee's health care provider.

How does the appeal process work?
The appeal may be made either orally or in writing. Upon submission of an appeal, the health care plan must notify the party within 3 business days of all the information the health care plan requires to evaluate the appeal.

What is the time frame of the appeals process?
Upon receipt of the required information, the health care plan must make a decision within 15 business days. The health care plan must orally notify the party filing the appeal, the enrollee, the enrollee's primary physician, and any health care provider who recommended the health care service involved in the appeal of its decision, with a written notice of the determination to follow.

What if my appeal qualifies as an expedited review?
Expedited reviews must be provided if a delay would significantly increase the risk to an enrollee's health or when extended services for an ongoing course of treatment are at issue.

What is the time frame for an expedited review?
The appeal can be made either orally or in writing. Upon submission of an appeal, the health care plan must notify the party within 24 hours of all the information the health care plan requires to evaluate the appeal. Upon receipt of the required information, the health care plan must make a decision

within 24 hours and orally notify the party filing the appeal, the enrollee, enrollee's primary physician, and any health care provider who recommended the health care service involved in the appeal of its decision, with a written notice of the determination to follow.

What information must be included in the written notice of decision?
The written notice of determination must include: clear and detailed reasons for the determination; the medical or clinical criteria for the determination, which must be based upon sound clinical evidence and reviewed on a periodic basis; and, in the case of an adverse determination, the procedures for requesting an external independent review.

Once I have exhausted the internal appeals process of my health care plan, do I have any other options?
Yes. If an appeal is denied, any involved party may request an external independent review.

Appeals Process

1. Enrollee/party submits appeal of adverse determination.
2. **Within 3 business days of receipt of appeal**, the health care plan must notify enrollee/party of all information needed to evaluate the appeal.
3. After the health care plan receives all information, it must, **within 15 business days**, render a decision on the appeal and orally notify enrollee/party, primary physician, and any health care provider involved, followed by written notice.

Expedited Appeals Process

(*when a delay could significantly increase the risk to enrollee's health*)

1. Enrollee/party submits request for expedited appeal.
2. **Within 24 hours of request**, the health care plan must notify enrollee/party of all information needed to evaluate the appeal.
3. After the health care plan receives all information, it must, **within 24 hours**, render a decision on the appeal and orally notify enrollee/party, primary physician, and any health care provider involved, followed by written notice.

THE RIGHT TO REQUEST AN EXTERNAL INDEPENDENT REVIEW

Who can request an external review of a health care plan's decision?
Once an adverse determination is made in the internal appeals process, any involved party has the option to demand an external review by an independent reviewer.

How does the appeals process work?
Notification of demand for an external review must be made in writing within 30 days of the date of receipt of the adverse determination from the internal appeals process. Remember to include all relevant information and documentation to support your request for services.

What is the time frame for the external independent review process?
Within 30 days of receiving a written request, the health care plan must provide for joint selection of an external independent reviewer. This reviewer must be a clinical peer, have no direct financial interest in connection with the case, and be unaware of the identity of the enrollee requesting the review. Your health care plan will give you a list of doctors from which to choose.

How long does the independent reviewer have to make a decision?
Within the same 30 day time frame, the health care plan must forward to the reviewer all medical records and supporting documents, a summary description of the issues, the criteria used in coming to a decision, and the medical reasons for the decision. Upon receipt of all these materials, the external reviewer has 5 days to make a determination of whether or not the claim or service is medically appropriate.

What if my appeal qualifies as an expedited review?
Expedited reviews must be provided when a delay would significantly increase the risk to an enrollee's health or when extended services for an ongoing course of treatment are at issue.

What is the time frame for an expedited review?
Health care plans must make a determination and provide notice of the determination within 24 hours of receipt of all information.

What if I do not agree with the decision made by the independent reviewer? Do I have any other avenues to pursue my dispute?
The decision of the independent reviewer is final. Once your health care plan has completed an external review process, you have exhausted your rights.

What happens if the external independent reviewer decides that the service or claim is medically necessary?
If the independent reviewer determines the services to be medically appropriate, then your health care plan must pay for the services.

Who has to pay for the external independent reviewer?
The health care plan is solely responsible for paying the fees of the external independent reviewer, whether or not the service or claim is determined to be medically appropriate.

External Independent Review Process

1. Enrollee receives written notice of adverse determination from internal appeal.
2. **Within 30 days of receipt of notice,** enrollee must send written request for external independent review.
3. **Within 30 days of receipt of request**, the health care plan should:
   - provide a mechanism for joint selection of an external independent reviewer.
   - forward medical records to the independent reviewer.
4. **Within 5 days of receipt of medical records**, the independent reviewer must render a decision.

Expedited Independent Review Process
(*when a delay could significantly increase the risk to enrollee's health*)
1. Party seeking an external independent reviewer notifies the health care plan.
2. Health care plan receives all information.
3. **Within 24 hours**, the health care plan must make a decision.

If you believe you were denied services to which you were entitled or require assistance in pursuing your appeal, contact the Illinois Attorney General's Health Care Helpline at 1-877-305- 5145 (TTY: 1-800-964-3013).

Please visit
www.IllinoisAttorneyGeneral.gov

Chicago
1-800-386-5438
TTY: 1-800-964-3013

Springfield
1-800-243-0618
TTY: 877-844-5461

Carbondale
1-800-243-0607
TTY: 877-675-9339

PUBLIC PROGRAMS

Many people are eligible for public health care programs but do not know it. The types of available programs and eligibility requirements vary widely across states. Some states have very generous programs that are open to a sizeable cross section of the population, while others target their programs to very specific populations and have stringent eligibility restrictions. In some states, both uninsured and privately insured individuals may be eligible.

Applying to public programs can be an important strategy for resolving medical debt because these programs may pay retroactively for health care services. However, there is always a time limit for coverage of past bills, so it is crucial to apply for public coverage as soon as possible after receiving medical services, or even prior to seeking care. Also, some public programs may only cover care provided by certain doctors, clinics and hospitals. It is nearly always worthwhile to apply—or apply again if time has passed—because program eligibility guidelines change frequently.

Medicare

Medicare is a federal health insurance program for disabled people and Americans age 65 and older. Medicare will not pay for past medical bills in most cases.

In Illinois, the Senior Health Insurance Program (SHIP) is a free statewide health insurance counseling service for Medicare beneficiaries and their caregivers. SHIP is sponsored by the Illinois Department of Insurance. To contact SHIP, please call (800) 548-9034 or email DOI.SHIP@illinois.gov.

Illinois Cares Rx provides prescription drug assistance to low-income seniors and disabled persons. For participants enrolled in Medicare Part D, Illinois Cares Rx helps lower the participants' copayments and cost-sharing. Illinois Cares Rx provides direct prescription drug coverage for participants who are not eligible for Medicare.

For more information, visit the Illinois Cares Rx website at http://www.illinoiscaresrx.com/.

Or to obtain a copy of the IL Office of the Attorney General's brochure on this program, go to: http://illinoisattorneygeneral.gov/consumers/Fact_Sheet--Medicare_Part%20D.pdf.

For more information about Medicare, visit: www.medicare.gov.

For help with Medicare-related issues, contact the Medicare Rights Center: www.medicarerights.org.

PUBLIC PROGRAMS

Illinois Medicaid, All Kids, and Other Public Programs

The Illinois Department of Healthcare and Family Services (HFS) offers many different healthcare programs for the people of Illinois. Programs include Medicaid, All Kids, FamilyCare, Moms & Babies or HFS Medical Benefits.

Two state agencies work together to help Illinoisans get HFS Medical Program benefits. The Department of Healthcare and Family Services administers health insurance programs for children, pregnant women, and adults who are residents of Illinois. The Department of Human Services (DHS) helps by taking applications for medical benefits. For more information call the HFS Health Benefits Hotline, Monday - Friday (except state holidays) 8:00 a.m. - 5:00 p.m. 1-800-226-0768. Persons using a TTY can call 1-887-204-1012. The call is free.

Or call the DHS Bureau of Customer Inquiry & Assistance Helpline at 1-800-843-6154, Monday - Friday (except state holidays), between 8:30 a.m. and 5:00 p.m. Persons using a teletypewriter (TTY) can call 1-800-447-6404. The call is free.

You may also contact your local DHS Family Community Resource Center. For more information, visit their websites at:

The Department of Healthcare and Family Services: http://www2.illinois.gov/hfs/Pages/default.aspx
The Illinois Department of Human Services (DHS): http://www.dhs.state.il.us/page.aspx?item=29722

Victims of Violent Crime

Violent crime is a senseless, often random act, and it is far too common in today's society. It is no longer enough to ensure that offenders receive the harshest punishment under the law. Victims and their families need support as they attempt to rebuild lives torn apart by tragedy. Attorney General Lisa Madigan has made it a priority to provide services to help victims meet their challenges and regain peace of mind. Programs administered by the Crime Victim Services Division include:

The Illinois Crime Victim Compensation Program provides direct financial assistance to innocent victims of violent crime to reimburse out-of-pocket expenses related to the crime.

The Domestic Violence Fund provides funding for legal advocacy, legal assistance, and legal services to victims of domestic violence who are or have been married or in a civil union. This fund is awarded from a portion of marriage license fees collected after June 1, 2008, and a portion of civil union license fees collected after June 1, 2011. Any public or private not-for-profit agency that provides services to victims of domestic violence may apply to the Illinois Attorney General for funding from the Domestic Violence Fund.

The Violent Crime Victim Assistance (VCVA) Program provides grants to victim and witness assistance programs throughout the state. Here, you will find links to the Quarterly Report, Eligibility Requirements, List of Grantees, RFP Information, and Application Kits. For more information, go to: http://illinoisattorneygeneral.gov/victims/index.html

LISA MADIGAN
ILLINOIS ATTORNEY GENERAL

Illinois Insurance Facts
Medicare Prescription Drug Coverage and Illinois Cares Rx

Medicare Prescription Drug Coverage Overview

Beginning January 1, 2006, the new voluntary Medicare prescription drug coverage, sometimes called Medicare Part D, will be available to people with Medicare. Medicare prescription drug plans may vary, but like other insurance, enrollees will pay a monthly premium and a share of the prescription drug costs. **Extra help** will be available to people with limited resources.

When Can You Join a Medicare Prescription Drug Plan?

People who have Medicare Part A and/or Part B can join a Medicare prescription drug plan between November 15, 2005 and May 15, 2006. If you don't enroll in Medicare prescription drug coverage when first eligible and later choose to enroll, in most cases, you will pay 1% more a month in premium for every month you were eligible and did not enroll. This additional amount will be based on the current monthly premium at the time of enrollment and will be required as long as you are enrolled. People with current drug coverage considered as good as or better than the standard Medicare prescription drug coverage will not pay this higher premium penalty.

What Does Standard Medicare Prescription Drug Coverage Look Like?

- On average, you pay a $32 monthly premium for standard Medicare prescription drug coverage. Some Medicare prescription drug plans will cost less than $32 and some will cost more. *
- You pay the first $250 in drug costs also know as the annual deductible.
- After the deductible, you pay 25% of drug costs up to $500 out-of-pocket and Medicare pays 75% of drug costs up to $1,500.
- You pay 100% of drug costs up to an additional $2,850 in drug costs. This is sometimes called the coverage gap.
- Once your total out-of-pocket expenses reach **$3,600 ($250 + $500 + $2,850)**, Medicare pays 95% of the drug costs and you pay the greater of 5% of drug costs or $2 for generics or $5 for brand name.

*All drug plans will have to provide at least the standard level of coverage set by Medicare. Some plans might offer more coverage and/or additional drugs.

What is Extra Help?

Individuals with limited income and resources can get extra financial help to pay for drug costs under the Medicare prescription drug coverage. People who qualify for extra help will have either reduced premiums or no premiums, reduced cost sharing amounts, and no coverage gap. The amount of extra help you receive depends upon the amount of income and assets you have.

Who Qualifies for Extra Help?

People with Medicare who also receive full Medicaid benefits, SSI recipients, and individuals enrolled in QMB, SLMB, and QI will automatically receive extra help to pay for prescription drug costs under the Medicare prescription drug coverage.

Individuals at or below 150% of poverty also qualify for extra help, but must apply through the Social Security Administration (SSA) to get this help. If you need an application, call 1-800-772-1213 or TTY 1-800-325-0778. Fill it out and send it back to the Social Security Administration in the envelope they give you.

What if I have SeniorCare or Circuit Breaker Pharmaceutical Assistance?

Governor Blagojevich recently signed a law that creates a new, improved program called **Illinois Cares Rx**, combining and improving Circuit Breaker Pharmaceutical Assistance and SeniorCare. In order to continue to receive state prescription assistance through Illinois Cares Rx and also be eligible for Medicare prescription drug coverage, you must:

1. Apply for Extra Help from the Social Security Administration **AND**
2. Enroll in a Medicare prescription drug plan that is coordinating with the state.

Which Medicare prescription drug costs will Illinois Cares Rx pay for people with Medicare?

Illinois Cares Rx will pay 100% of the standard premium (not including any late enrollment fee/penalty) and the deductible for covered drugs. The participant pays $2 co-payment for generic and $5 co-payment for brand name drugs. Once the State and Medicare pays $1750 in drug costs, you pay 20% per prescription plus any required co-payments. After $5100 of total drug costs, you pay 5% co-insurance and Medicare pays 95% of the drug costs.

What if I don't qualify for Medicare, will I still be able to have Circuit Breaker Pharmaceutical Assistance and/or SeniorCare?

Yes, Illinois Cares Rx will provide benefits very similar to benefits currently covered by SeniorCare and Circuit Breaker Pharmaceutical Assistance for people not eligible for Medicare. Participants pay $2 co-pay for generic drugs and $5 co-pay for brand name drugs. Once Illinois Cares Rx has paid $1,750 in benefits, you pay 20% of the cost of each prescription in additional to any required co-pays.

For more information, contact the Senior Health Insurance Program (SHIP):

Illinois Department of Financial and Professional Regulation
Division of Insurance
320 West Washington Street
Springfield, IL 62767-0001
1-800-548-9034 (toll-free in Illinois)
217-785-9021 (outside Illinois)
217-524-4872 (TDD)
www.idfpr.com
SHIP@ins.state.il.us

Office of the Illinois Attorney General

Chicago	Springfield	Carbondale
100 West Randolph Street	500 South Second Street	1001 East Main Street
Chicago, IL 60601	Springfield, IL 62706	Carbondale, IL 62901
(312) 814-3000	(217) 782-1090	(618) 529-6400/6401
TTY: (312) 814-3374	TTY: (217) 785-2771	TTY: (618) 529-6403

Please visit www.IllinoisAttorneyGeneral.gov

CHARITY CARE AND FINANCIAL ASSISTANCE

An important step in resolving medical bills is to ask medical providers about their charity care and financial assistance policies. Many hospitals offer charity care or financial assistance to uninsured and underinsured patients who are unable to afford part or all of their medical bills. Other medical providers—ambulance companies and doctors' groups, laboratories and so on—may also offer charity care or financial assistance to their patients. Charity care is not a public program. It is a form of private financial assistance offered by medical providers to their low-income or otherwise vulnerable patients.

Charity care guidelines vary so widely between different medical providers that it is impossible to make a generalization about eligibility standards. Learn more about your local medical providers' charity care policies by calling their billing offices—speak to a Manager of Patient Accounts or Chief Financial Officer (CFO).

In many cases, both uninsured patients and insured patients who owe out-of-pocket medical costs can qualify for charity care. Some providers may require an official recent denial from a public program, particularly Medicaid, to qualify for the hospital-based charity care or financial assistance program.

Illinois Context

Illinois has enacted the Fair Patient Billing Act, a law that protects Illinois patients from unfair hospital billing and collection practices. This law prohibits hospitals and their collection agents from using abusive or deceptive practices during the debt collection process. It prohibits legal action against uninsured patients for uncollected hospital bills if they have demonstrated that they cannot meet their financial obligations because of insufficient income and assets.

Under the Fair Patient Billing Act, all Illinois hospitals are required (among other things) to notify patients of the availability of financial assistance, provide detailed billing information, and follow a specific protocol prior to submitting patients to collection actions.

The Act has a specific provision concerning insured patients who may have a difficult time paying their out-of-pocket share of a bill in one lump sum. According to the Act, a hospital may not refer a bill for collections without first offering an insured patient the opportunity to request a reasonable payment plan for the amount personally owed by the patient. A "reasonable payment plan," according to the Act, is one that takes into account the patient's available income and assets, the amount owed, and any prior payments the patient has made.

For assistance in resolving a billing dispute, and to ensure that the hospital is meeting its obligations under the Fair Patient Billing Act, Contact the IL Office of the Attorney General's Health Care Helpline at **1-877-305-5145; TTY: 1-800-964-3013**.

CHARITY CARE AND FINANCIAL ASSISTANCE

Call medical providers to ask about charity care:

- Call the provider's billing office and ask for a written copy of the charity care and financial assistance policies.
- Ask for charity care and financial assistance applications.
- Look at the medical bills: do they mention availability of "financial assistance programs"?
- If the provider is a hospital, ask the billing office to connect you with a financial counselor.

Write a letter to request charity care and financial assistance:

- It is often more effective to put this kind of request in writing
- See sample letters in this section:
  - Request for Financial Assistance from a Medical Provider
  - Hospital Violation of American Hospital Association Guidelines

Hospitals and Charity Care

While most hospitals offer charity care to their patients, non-profit hospitals have extra responsibility to do so because they receive tax breaks. Non-profit hospitals receive tax benefits due to their non-profit status and, therefore, are required to provide community benefits. Some non-profit hospitals have come under scrutiny from advocacy groups and the government for not providing enough community benefits, particularly charity care.

Included in the Affordable Care Act were new requirements pertaining to hospitals that are exempt from federal tax. The Affordable Care Act added new requirements that hospitals must comply with in order to maintain the federal tax exemption. These new provisions require non-profit hospitals to have written financial assistance policies that outline the criteria for eligibility and the type of assistance provided (i.e. free care, discounted care, medical indigent or hardship). Hospitals must also have written debt collection policies and they are prohibited from using extraordinary collection actions.

The new requirements direct hospitals to provide proper notification of financial assistance prior to initiating collection action. Such notification includes providing information on admission, prior to discharge, and on notices in billing communication

The ACA provisions also limit the maximum fees that can be charged to patients eligible for financial assistance. Hospitals must clarify whether eligible patients are billed more than patients with insurance.

In 2003, the American Hospital Association (AHA) released its "Guidelines for Billing and Collections Practices." The AHA website states that more than 4,200 non-profit and for-profit hospitals have "confirmed their commitment" to uphold these guidelines, which include offering charity care and financial assistance to patients who cannot afford their bills. Even for hospitals that have signed onto the AHA Guidelines, clients may still have to ask billing managers about their institutions'

charity care policies. The "Guidelines" state that hospitals should:

- Respond promptly to patients' questions about their bills and to requests for financial assistance.
- Use a billing process that is clear, concise, correct and patient friendly.
- Ensure that staff members who work closely with patients are educated about hospital billing, financial assistance and collection policies and practices.
- Make available for review by the public specific information in a meaningful format about what they charge for services.
- Make available to the public information on hospital-based charity care policies and other known programs of financial assistance.
- Have understandable, written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs.

For a copy of the Guidelines and a list of the hospitals that have confirmed their commitment, visit www.aha.org and click on "billings and collections" under the "issues" tab. A copy of the Guidelines is included in this section.

TIP

Before asking hospitals about charity care, look to see if they confirmed their commitment to the AHA Guidelines. If so, use language from the Guidelines to ask about charity care and other discounts.

American Hospital Association

Hospital Billing and Collection Practices

Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association

The mission of each and every hospital in America is to serve the health care needs of people in their communities 24 hours a day, seven days a week. Their task, and the task of their medical staffs, is to care and to cure. America's hospitals are united in providing care based on the following principles:

- Treat all patients equitably, with dignity, with respect and with compassion.
- Serve the emergency health care needs of everyone, regardless of a patient's ability to pay for care.
- Assist patients who cannot pay for part or all of the care they receive.
- Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep hospitals' doors open for all who may need care in a community.

Hospitals' work is made more difficult by America's fragmented health care system … a system that leaves *millions* of people unable to afford the health care services they need … a system in which federal and state governments and some private insurers do not meet their responsibilities to cover the costs of caring for Medicare, Medicaid or privately insured patients … a system in which payments do not recognize the unreimbursed services provided by hospitals … a system in which a complex web of regulations prevents hospitals from doing even more to make care affordable for their patients. Today's fragmented health care system does not serve Americans well in many ways. It is in need of significant change as each day leaves more and more hospitals unable to make ends meet.

While most Americans have insurance coverage for their unexpected health care needs, more than 43 million people do not. Some of these people can pay for the health care they

may need, but America's hospitals treat millions of patients each year who can make only minimal payment, or no payment at all. In the absence of adequate insurance coverage for all, America's hospitals must find ways to both serve and survive.

Unfortunately, a vast and confusing array of federal laws, rules and regulations make it much more difficult than it should be for hospitals to respond to the concerns of patients of limited means who are unable to pay their hospital bills. Government must commit to removing these regulatory barriers to allow hospitals to do even more to make care affordable for patients who cannot pay for part or all of the care they receive.

The following guidelines outline how hospitals can better serve their patients. Hospitals have been following some of these guidelines for years as they work each day to find new ways to best meet their patients' needs.

Guidelines

Helping Patients with Payment for Hospital Care

Communicating Effectively

- Hospitals should provide financial counseling to patients about their hospital bills and should make the availability of such counseling widely known.
- Hospitals should respond promptly to patients' questions about their bills and to requests for financial assistance.
- Hospitals should use a billing process that is clear, concise, correct and patient friendly.
- Hospitals should make available for review by the public specific information in a meaningful format about what they charge for services.

Helping Patients Qualify for Coverage

- Hospitals should make available to the public information on hospital-based charity care policies and other known programs of financial assistance.
- Hospitals should communicate this information to patients in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in their communities.
- Hospitals should have understandable, written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs.
- Hospitals should share these policies with appropriate community health and human services agencies and other organizations that assist people in need.

Ensuring Hospital Policies are Applied Accurately and Consistently

- Hospitals should ensure that all written policies for assisting low-income patients are applied consistently.
- Hospitals should ensure that staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections as well as nurses, social workers, hospital receptionists and others) are educated about hospital billing, financial assistance and collection policies and practices.

Making Care More Affordable for Patients with Limited Means

- Hospitals should review all current charges and ensure that charges for services and procedures are reasonably related to both the cost of the service and to meeting all of the community's health care needs, including providing the necessary subsidies to maintain essential public services.
- Hospitals should have policies to offer discounts to patients who do not qualify under a charity care policy for free or reduced cost care and who, after receiving financial counseling from the hospital, are determined to be eligible under the hospital's criteria for such discounts (pending needed federal regulatory clarification). Policies should clearly state the eligibility criteria, amount of discount, and payment plan options.

Ensuring Fair Billing and Collection Practices

- Hospitals should ensure that patient accounts are pursued fairly and consistently, reflecting the public's high expectations of hospitals.
- Hospitals should define the standards and scope of practices to be used by outside collection agencies acting on their behalf, and should obtain agreement to these standards in writing from such agencies.
- Hospitals should implement written policies about when and under whose authority patient debt is advanced for collection.

Hospitals in some states may need to modify the use of these guidelines to comply with state laws and regulations.

Hospitals exist to serve. Their ability to serve well requires a relationship with their communities built on trust and compassion. These guidelines are intended to strengthen that relationship and to reassure patients, regardless of their ability to pay, of hospitals' commitment to caring.

AHA Confirmation of Commitment

The following hospitals have signed a Confirmation of Commitment to the AHA's Principles and Guidelines on Hospital Billing and Collections Practices*

Benewah Community Hospital	Saint Maries	Idaho
Bingham Memorial Hospital	Blackfoot	Idaho
Bonner General Hospital	Sandpoint	Idaho
Boundary Community Hospital	Bonners Ferry	Idaho
Cascade Medical Center	Cascade	Idaho
Cassia Regional Medical Center	Burley	Idaho
Clearwater Valley Hospital and Clinics	Orofino	Idaho
Eastern Idaho Regional Medical Center	Idaho Falls	Idaho
Elmore Medical Center	Mountain Home	Idaho
Franklin County Medical Center	Preston	Idaho
Gritman Medical Center	Moscow	Idaho
Idaho Elks Rehabilitation Hospital	Boise	Idaho
Kootenai Medical Center	Coeur D'Alene	Idaho
Lost Rivers District Hospital	Arco	Idaho
Madison Memorial Hospital	Rexburg	Idaho
Magic Valley Regional Medical Center	Twin Falls	Idaho
McCall Memorial Hospital	McCall	Idaho
Mercy Medical Center	Nampa	Idaho
Minidoka Memorial Hospital and Extended Care Facil	Rupert	Idaho
Oneida County Hospital	Malad City	Idaho
Portneuf Medical Center	Pocatello	Idaho
Saint Alphonsus Regional Medical Center	Boise	Idaho
St. Benedicts Family Medical Center	Jerome	Idaho
St. Joseph Regional Medical Center	Lewiston	Idaho
St. Luke's Regional Medical Center	Boise	Idaho
St. Mary's Hospital	Cottonwood	Idaho
Syringa General Hospital	Grangeville	Idaho
Teton Valley Hospital and Surgicenter	Driggs	Idaho
Walter Knox Memorial Hospital	Emmett	Idaho
Weiser Memorial Hospital	Weiser	Idaho
West Valley Medical Center	Caldwell	Idaho

Illinois

Abraham Lincoln Memorial Hospital	Lincoln	Illinois
Advocate Bethany Hospital	Chicago	Illinois
Advocate Christ Medical Center	Oak Lawn	Illinois
Advocate Good Samaritan Hospital	Downers Grove	Illinois
Advocate Good Shepherd Hospital	Barrington	Illinois
Advocate Illinois Masonic Medical Center	Chicago	Illinois
Advocate Lutheran General Hospital	Park Ridge	Illinois
Advocate South Suburban Hospital	Hazel Crest	Illinois
Advocate Trinity Hospital	Chicago	Illinois
Alexian Brothers Behavioral Health Hospital	Hoffman Estates	Illinois

** The Absence of a hospital's name does not suggest that its policies and practices do not meet or exceed these Principles and Guidelines. For questions, contact your local hospital.*

AHA Confirmation of Commitment

The following hospitals have signed a Confirmation of Commitment to the AHA's Principles and Guidelines on Hospital Billing and Collections Practices*

Anderson Hospital	Maryville	Illinois
Blessing Hospital	Quincy	Illinois
BroMenn Healthcare System	Normal	Illinois
Carle Foundation Hospital	Urbana	Illinois
Carlinville Area Hospital	Carlinville	Illinois
Central DuPage Hospital	Winfield	Illinois
CGH Medical Center	Sterling	Illinois
Children's Memorial Hospital	Chicago	Illinois
Clay County Hospital	Flora	Illinois
Community Hospital of Ottawa	Ottawa	Illinois
Community Medical Center at Western Illinois	Monmouth	Illinois
Community Memorial Hospital	Staunton	Illinois
Condell Medical Center	Libertyville	Illinois
Crawford Memorial Hospital	Robinson	Illinois
Crossroads Community Hospital	Mount Vernon	Illinois
Decatur Memorial Hospital	Decatur	Illinois
Greenville Regional Hospital	Greenville	Illinois
Edward Hospital	Naperville	Illinois
Elmhurst Memorial Hospital	Elmhurst	Illinois
Evanston Northwestern Healthcare	Evanston	Illinois
Fairfield Memorial Hospital	Fairfield	Illinois
Ferrell Hospital	Eldorado	Illinois
FHN Memorial Hospital	Freeport	Illinois
Franklin Hospital	Benton	Illinois
Galena-Stauss Hospital and Healthcare Center	Galena	Illinois
Gibson Area Hospital and Health Services	Gibson City	Illinois
GlenOaks Hospital	Glendale Heights	Illinois
Good Samaritan Regional Health Center	Mount Vernon	Illinois
Gottlieb Memorial Hospital	Melrose Park	Illinois
Graham Hospital	Canton	Illinois
Hamilton Memorial Hospital District	McLeansboro	Illinois
Hammond-Henry Hospital	Geneseo	Illinois
Harrisburg Medical Center	Harrisburg	Illinois
Hartgrove Hospital	Chicago	Illinois
Herrin Hospital	Herrin	Illinois
Hillsboro Area Hospital	Hillsboro	Illinois
Hinsdale Hospital	Hinsdale	Illinois
Holy Cross Hospital	Chicago	Illinois
Holy Family Medical Center	Des Plaines	Illinois
Illini Community Hospital	Pittsfield	Illinois
Genesis Medical Center, Illini Campus	Silvis	Illinois
Illinois Valley Community Hospital	Peru	Illinois

** The Absence of a hospital's name does not suggest that its policies and practices do not meet or exceed these Principles and Guidelines. For questions, contact your local hospital.*

AHA Confirmation of Commitment

The following hospitals have signed a Confirmation of Commitment to the AHA's Principles and Guidelines on Hospital Billing and Collections Practices*

Ingalls Memorial Hospital	Harvey	Illinois
Iroquois Memorial Hospital and Resident Home	Watseka	Illinois
Jackson Park Hospital and Medical Center	Chicago	Illinois
Jersey Community Hospital	Jerseyville	Illinois
John and Mary Kirby Hospital	Monticello	Illinois
Katherine Shaw Bethea Hospital	Dixon	Illinois
Kewanee Hospital	Kewanee	Illinois
Kindred Hospital-Sycamore	Sycamore	Illinois
Kishwaukee Community Hospital	De Kalb	Illinois
La Grange Memorial Hospital	La Grange	Illinois
La Rabida Children's Hospital	Chicago	Illinois
Lake Forest Hospital	Lake Forest	Illinois
Lawrence County Memorial Hospital	Lawrenceville	Illinois
Lincoln Park Hospital	Chicago	Illinois
Linden Oaks Hospital at Edward	Naperville	Illinois
Little Company of Mary Hospital and Health Care Cer	Evergreen Park	Illinois
Loretto Hospital	Chicago	Illinois
Louis A. Weiss Memorial Hospital	Chicago	Illinois
Loyola University Medical Center	Maywood	Illinois
Marianjoy Rehabilitation Hospital	Wheaton	Illinois
Marshall Browning Hospital	Du Quoin	Illinois
Mason District Hospital	Havana	Illinois
Massac Memorial Hospital	Metropolis	Illinois
McDonough District Hospital	Macomb	Illinois
Memorial Hospital	Carthage	Illinois
Memorial Hospital	Chester	Illinois
Memorial Hospital of Carbondale	Carbondale	Illinois
Memorial Medical Center	Springfield	Illinois
Centegra Memorial Medical Center	Woodstock	Illinois
Mendota Community Hospital	Mendota	Illinois
Mercer County Hospital	Aledo	Illinois
Mercy Harvard Hospital	Harvard	Illinois
Mercy Hospital and Medical Center	Chicago	Illinois
Methodist Medical Center of Illinois	Peoria	Illinois
Morris Hospital & Healthcare Centers	Morris	Illinois
Morrison Community Hospital	Morrison	Illinois
Mount Sinai Hospital Medical Center of Chicago	Chicago	Illinois
Centegra Northern Illinois Medical Center	McHenry	Illinois
Northwest Community Healthcare	Arlington Heights	Illinois
Northwestern Memorial Hospital	Chicago	Illinois
Oak Forest Hospital of Cook County	Oak Forest	Illinois
OSF Saint Anthony Medical Center	Rockford	Illinois

** The Absence of a hospital's name does not suggest that its policies and practices do not meet or exceed these Principles and Guidelines. For questions, contact your local hospital.*

AHA Confirmation of Commitment

The following hospitals have signed a Confirmation of Commitment to the AHA's Principles and Guidelines on Hospital Billing and Collections Practices*

OSF Saint Francis Medical Center	Peoria	Illinois
OSF Saint James - John W. Albrecht Medical Center	Pontiac	Illinois
OSF St. Joseph Medical Center	Bloomington	Illinois
OSF St. Mary Medical Center	Galesburg	Illinois
Our Lady of the Resurrection Medical Center	Chicago	Illinois
Palos Community Hospital	Palos Heights	Illinois
Pana Community Hospital	Pana	Illinois
Paris Community Hospital	Paris	Illinois
Passavant Area Hospital	Jacksonville	Illinois
Pekin Hospital	Pekin	Illinois
Perry Memorial Hospital	Princeton	Illinois
Pinckneyville Community Hospital	Pinckneyville	Illinois
Proctor Hospital	Peoria	Illinois
Provena Covenant Medical Center	Urbana	Illinois
Provena Mercy Center	Aurora	Illinois
Provena Saint Joseph Hospital	Elgin	Illinois
Provena Saint Joseph Medical Center	Joliet	Illinois
Provena St. Mary's Hospital	Kankakee	Illinois
Provena United Samaritans Medical Center	Danville	Illinois
R M L Specialty Hospital	Hinsdale	Illinois
Rehabilitation Institute of Chicago	Chicago	Illinois
Resurrection Medical Center	Chicago	Illinois
Richland Memorial Hospital	Olney	Illinois
Riveredge Hospital	Forest Park	Illinois
Riverside Medical Center	Kankakee	Illinois
Rochelle Community Hospital	Rochelle	Illinois
Rockford Memorial Hospital	Rockford	Illinois
Rush North Shore Medical Center	Skokie	Illinois
Rush Oak Park Hospital	Oak Park	Illinois
Rush University Medical Center	Chicago	Illinois
Rush-Copley Medical Center	Aurora	Illinois
Saint Anthony Hospital	Chicago	Illinois
Saint Anthony's Health Center	Alton	Illinois
Saint's Mary & Elizabeth Medical Center, Claremont A	Chicago	Illinois
Saint Francis Hospital	Evanston	Illinois
St. Francis Hospital & Health Center	Blue Island	Illinois
Saint Joseph Hospital	Chicago	Illinois
Saint's Mary & Elizabeth Medical Center, Division Str	Chicago	Illinois
Salem Township Hospital	Salem	Illinois
Sarah Bush Lincoln Health Center	Mattoon	Illinois
Sarah D. Culbertson Memorial Hospital	Rushville	Illinois
Schwab Rehabilitation Hospital	Chicago	Illinois

** The Absence of a hospital's name does not suggest that its policies and practices do not meet or exceed these Principles and Guidelines. For questions, contact your local hospital.*

AHA Confirmation of Commitment

The following hospitals have signed a Confirmation of Commitment to the AHA's Principles and Guidelines on Hospital Billing and Collections Practices*

Shelby Memorial Hospital	Shelbyville	Illinois
Sherman Hospital	Elgin	Illinois
Sparta Community Hospital	Sparta	Illinois
St. Alexius Medical Center	Hoffman Estates	Illinois
St. Anthony's Memorial Hospital	Effingham	Illinois
St. Elizabeth's Hospital	Belleville	Illinois
St. Francis Hospital	Litchfield	Illinois
St. James Hospital and Health Centers	Chicago Heights	Illinois
St. John's Hospital	Springfield	Illinois
St. Joseph Memorial Hospital	Murphysboro	Illinois
St. Joseph's Hospital	Breese	Illinois
St. Margaret's Hospital	Spring Valley	Illinois
St. Mary's Hospital	Centralia	Illinois
St. Mary's Hospital	Decatur	Illinois
St. Mary's Hospital	Streator	Illinois
St. Vincent Memorial Hospital	Taylorville	Illinois
Swedish Covenant Hospital	Chicago	Illinois
SwedishAmerican Hospital	Rockford	Illinois
Thorek Hospital and Medical Center	Chicago	Illinois
Touchette Regional Hospital	East St Louis	Illinois
Trinity Medical Center-West	Rock Island	Illinois
University of Chicago Hospitals	Chicago	Illinois
Valley West Community Hospital	Sandwich	Illinois
Van Matre HEALTHSOUTH Rehabilitation Hospital	Rockford	Illinois
Vista Health-Provena Saint Therese Medical Center	Waukegan	Illinois
Vista Health-Victory Memorial Hospital	Waukegan	Illinois
Washington County Hospital	Nashville	Illinois
West Suburban Medical Center	Oak Park	Illinois
Westlake Hospital	Melrose Park	Illinois

Indiana

Adams County Memorial Hospital	Decatur	Indiana
Ball Memorial Hospital	Muncie	Indiana
Bedford Regional Medical Center	Bedford	Indiana
Blackford Community Hospital	Hartford City	Indiana
Bloomington Hospital	Bloomington	Indiana
Bluffton Regional Medical Center	Bluffton	Indiana
Cameron Memorial Community Hospital	Angola	Indiana
Clarian Health Partners	Indianapolis	Indiana
Clark Memorial Hospital	Jeffersonville	Indiana
Columbus Regional Hospital	Columbus	Indiana
Community Health Network	Indianapolis	Indiana
Community Hospital	Munster	Indiana

** The Absence of a hospital's name does not suggest that its policies and practices do not meet or exceed these Principles and Guidelines. For questions, contact your local hospital.*

NEGOTIATING MEDICAL BILLS

Most Americans are accustomed to paying fixed prices for goods and services. It might come as a surprise that medical bills in the United States are highly negotiable. In fact, people (especially the uninsured) who pay the initial prices offered to them by medical providers are likely being over-charged.

An important reason that medical bills are negotiable has to do with the nature of health insurance in this country. Different people who receive the exact same medical services are often expected to pay different prices depending on whether or not they have insurance and, if so, what insurance they have. Insurance companies negotiate "discounted" prices for their members at the providers where their subscribers are authorized to receive medical care ("in-network" providers). The same insurance company will pay a lower percentage of the patient's cost for the same care received at "out-of-network" providers. Other insurance companies negotiate a flat discount no matter where one goes for care. Even with steep "discounts," many medical providers can still make a good profit on the payments they receive.

Uninsured people do not have an insurance company negotiating on their behalf, so they are expected to pay much higher rates (sometimes called the "sticker price") for the same care that insurance companies get at "discounted" prices. Uninsured people are usually those who can least afford health care, yet they face the highest prices.

Insured people whose insurance does not cover certain services will be charged the sticker price—as if they were uninsured—for "uncovered services." One consequence of this system is that there is almost always room to negotiate medical bills.

TIP

Ask whether the provider has a financial assistance or discount policy. For non-profit hospitals, call attention to the IL Fair Patient Billing Act and the new provisions under the Affordable Care Act that require hospitals to assist patients with demonstrated financial need.

Reasons Why Negotiating Medical Bills Is Worth A Try:

- Medical bills can contain errors
- People might be eligible for charity care and not know it
- Providers may want to get something rather than nothing
- Providers commonly offer bill discounts
- Affordable payment plans are often available

NEGOTIATING MEDICAL BILLS

First Steps

The first step to resolving medical bills is to confront the problem directly: people should deal with their medical bills as soon as possible. Upon receiving a medical bill, people should contact the provider immediately even if the bill seems unaffordable. Clients may not know that they are eligible for a public program (see "Public Programs") or provider-based financial assistance (see "Charity Care.") Likewise, private insurers may have incorrectly denied or improperly processed a medical claim—clients can advocate with private insurers and exercise their appeal rights (see "Private Health Insurance Advocacy.")

In most cases, unpaid medical bills will eventually be sent to collections. It is more difficult to resolve bills that have been sent to a collections agency (see "Medical Bills in Collections"). Furthermore, collections agencies often report medical bills to credit bureaus, which can hurt a person's credit (see "Medical Bills on Credit Reports.")

Beyond ruining people's credit, some medical providers—or the collections agencies they use to collect bills—may file lawsuits or use other tactics to exact payment. In some cases, these agencies put liens on people's property, attach bank accounts, or sue them in court. Although these consequences are less common than effects on credit, some medical providers do take extreme measures.

TIP

Clients should be careful about:

- Paying medical bills before paying rent/mortgage, utilities, food, or other necessities.
- Borrowing against their homes or another asset to pay for medical bills.
- Using a credit card to pay medical bills unless they can pay off the balance at the end of the month.

To Begin Resolving Their Medical Debt

Clients Should:

- Gather all available information and documentation about their medical bills and insurance coverage (see ***Action Plan Worksheet I: Gathering Information***)
- Work directly with the billing office of a medical provider to negotiate bill discounts and payment plans (see "***Negotiating Medical Bills***" and "***Medical Bills in Collections***".)

Clients Should NOT:

- Ignore medical bills— they do not go away.
- Agree to a monthly payment they cannot afford.

NEGOTIATING MEDICAL BILLS

Understanding Medical Bills

Before people pay their medical bills, it is important to determine whether they are being charged fairly and appropriately for the medical care that they received.

1. Call the medical provider's billing office and ask for a copy of an itemized bill.
The bills that clients receive in the mail are rarely itemized. In other words, they don't contain a very detailed and long list of services, medical supplies, and treatments that the patient received. An itemized bill should show, for instance, the cost of aspirin pills offered to a patient after surgery, in addition to room charges for an over night stay. The itemized bill may show charges as low as one or two dollars for some items.

2. Ask medical providers to put bills on hold from going to collections.
Asking for an itemized bill can demonstrate to providers that clients are proactively dealing with their bills. Request that the billing office update the status of the accounts to "pending." Clients should say that they are working on paying their medical bills but that they need more time to review the details, as well as deal with their insurance company (if applicable), and eligibility for public programs and charity care.

3. Check itemized medical bill for errors and charges that seem unnecessarily high.
Medical bills commonly contain errors and excess charges. Examine the bills to ensure that clients were not billed for any services that they did not receive. Review that the client's name, insurance information, type of care, length of hospital stay, and other information are all correctly marked on the bill. Medical bills are often difficult to understand, so do not hesitate to ask the billing office to explain the details.

4. Ask about getting patient medical records.
If clients think that they were charged for services they didn't receive, it is important to verify patient medical records. Providers may charge copying fees for medical records, so ask what it costs to order them. The client's primary care physician may be able to request the records for free, however. Compare the medical records with the client's itemized bills to see if there are any inconsistencies between documented services and charges.

5. Challenge/dispute incorrect billing.
If specific services were not recorded in the medical records or there were other errors in the medical bills, then clients have excellent grounds to challenge the charges. Ask the billing office to correct any mistakes or errors—a manager of the billing department or Chief Financial Officer (CFO) would be in the best position to deal with problems of this sort. If making a verbal request does not work, ask about the provider's "grievance process" for disputing mistakes on medical bills. If they do not have a formal process, send a letter stating your grievances to the CFO and Manager of Patient Accounts; also send a copy of the letter to your state Attorney General. Make sure that clients keep copies for their own records.

TIP
Try to identify an ally in the billing department. Work to build relationships with billing managers, rather than treating them like faceless bureaucrats.

NEGOTIATING MEDICAL BILLS

Tips for Calling Medical Providers

- Call the billing office of a medical provider
- Begin speaking with the clerk who answers the phone in the billing office
  - Ask to speak with a Financial Counselor to apply for public programs
  - Ask about screening for financial assistance and charity care
  - Ask about discounts, payment plans, or another payment arrangement
  - Ask about getting future care: Will the provider continue to see patients if past bills are not paid? Does the provider require pre-payment for future care?
  - Collect any relevant documents that are missing (itemized medical bills, patient medical records, charity care and financial assistance policies, etc.)
- If the clerk is unhelpful, ask to speak with a manager in the billing department (for example, the Manager of Patient Accounts or Manager of Credit and Collections)
  - Ask the manager about charity care, public programs, negotiating bills
  - Climb up the administrative ladder and speak with the CFO if necessary
- Always be polite with the billing people, even when frustrated
- Work directly with the billing office of a medical provider to negotiate bill discounts and payment plans (see "Medical Bills in Collections.")

If the client is unable to call for his/herself, a friend, family member, or advocate can call the provider on the client's behalf:

- Client will need to be on the phone to give permission to the provider to speak about the case
- A three-way call can work well
- To get prior authorization to speak on a client's behalf, an advocate must fill out a written release form and send it to the provider (see HIPAA release form).

Keep good records when speaking with medical providers, insurers, and public programs. Whenever clients speak with someone about their medical bills, they should write down:

- Date and time of the call/meeting
- Name of the organization or institution
- Name of person client speaks with
- Job title of person client speaks with
- Contact information for person client speaks with
- Questions asked
- Answers received

Suggested Language To Use When Contacting a Billing Office

"Hi, I'm following up about my medical bill. I'm calling to figure out if there are any programs available to help me cover this bill. I also want to make sure that everything in my account is correct before paying."

"Please send me a copy of my itemized bill."

"May I please speak with the Manager of Patient Accounts or the Manager of Credit and Collections?"

"Please update the status of my account to 'pending' and put my bills on hold from collections while I review the details of my bill and arrange payment."

NEGOTIATING MEDICAL BILLS

Negotiating Discounts with Medical Providers

Even if a provider refuses to offer charity care or financial assistance, patients may still be able to receive significant discounts on their medical bills.

- Medical providers can offer payment discounts and may completely forgive bills in some cases
- Always ask for a discount.
- Explain hardships that you face—a personal story can make the difference.
- Build relationships with billing managers—do not just speak with the clerk who answers the phone in the billing office. Climb up the administrative hierarchy.
- Ask to speak with the Manager of Patient Accounts or the Chief Financial Officer (CFO). When negotiating bills, the billing clerk will not be helpful in most cases.
- Writing a letter to the medical provider can be an effective method of requesting a discount or bill forgiveness (see sample letter: "Request for bill forgiveness from a medical provider.")

TIP

Offer to pay the entire bill in full if they give an affordable discount.

TIP

With hospitals, call attention to the American Hospital Association (AHA) guidelines when asking about charity care, financial assistance, and bill discounts.

Suggested Language To Use When Negotiating *Discounts* with Providers

"I would appreciate it if my charges could be reduced to the negotiated rate—the amount that private insurance companies or Medicare would pay for the services."

"I want to pay my medical bills but the charges are unaffordable."

"Could we settle the account for a discounted price?"

"I can afford to pay $___ per month." (name a discounted price that you can reasonably afford)"

NEGOTIATING MEDICAL BILLS

Negotiating Payment Plans with Medical Providers

Whether or not one receives bill discounts, medical providers should offer extended payment plans. People do not have to accept the first plan that the billing manager offers to them. Instead, people should decide for themselves what is actually affordable, and bargain from there: use recent pay stubs, tax returns, and any other financial information to back up the case. People should never agree to a payment plan that they cannot afford.

- People should decide in advance how much they can realistically pay per month for each bill.
- Many providers ask patients to pay off an entire bill within a set time period: six months or two years, for example. This time period is often negotiable
- Ask for interest-free payment plans
  - Only agree to a payment plan that will be affordable every month
  - Get written agreements for payment plans from providers
- Caution: people can be sent to collections they are paying every month but do not have a written payment plan agreement
  - Request monthly statements that record payments and the remaining balance

For more information: Please see the "Confirmation of Settlement or Payment Plan" letter in the Sample Letters section.

TIP

Most providers will agree to set up an interest-free payment plan, so don't hesitate to challenge any payment plans where they require interest payments.

Suggested Language To Use When Negotiating *Payment Plans* with Providers

"I want to pay my bills, but I don't have the money to pay them all at once."

"Please send me monthly statements showing my payments and remaining account balance."

"May I please set up an interest-free payment plan?"

"Please send me written confirmation about this payment plan."

"I can pay $_____ per month. Can we agree to that amount?"

MEDICAL BILLS IN COLLECTIONS

Hospitals and other medical providers can, and often do, send unpaid bills to collection agencies. Many people report feeling disrespected and even harassed by agencies that aggressively pursue payment. Some collection agencies report to credit bureaus and may charge interest and fees on unpaid medical bills, where many medical providers do not. Medical bills that are sent to collection often end up as negative marks on peoples' credit reports.

People can avoid these consequences by dealing with their bills immediately and by working directly with the billing office or business office of their medical providers.

The most important piece of advice for clients is: Do not ignore medical bills, even if they seem unaffordable!

People will be more effective:

- If the collector is part of the hospital or other provider's internal billing system
- If the collector works on behalf of a provider

People will be less effective (but don't give up!):

- If old debt is already on the client's credit report
- If medical debt has been sold from one collection agency to another

While some medical providers prohibit their sub-contracted collectors from reporting medical bills to the credit bureaus, most providers allow this practice.

Working with Collection Agencies

There are two main ways that people can deal with medical bills in collection:

1) Bypass the collection agency and work directly with the medical provider

- Ask the medical provider's Manager of Patient Accounts or Chief Financial Officer to pull the bill back from collection and work directly with the client.
- Make sure that the client has been screened for public programs and charity care—if not, ask the provider to screen him/her.

2) Attempt to work with the collection agency

- Ask the collector directly for a steep bill discount (50% discounts, or more, are possible.)
- Contact the collector in writing about an affordable payment arrangement.
- Ask to speak with a manager of the collection agency.
- Negotiate a deal with the collection agency manager where they will remove the collection account from the client's credit report if he/she pays (some or all of) the bill.

TIP

If a collection agency is calling too frequently or is harassing a client, send a cease communications and/or stop harassment letter (see *sample letters to collections agencies*.)

MEDICAL BILLS IN COLLECTIONS

NOTE:
Some providers maintain control over their accounts even if outsourced, while other providers sell their accounts and do not have any authority to settle the medical debt.

Important: It is always better to work directly with the medical provider rather than a collection agency.

Suggested Language To Use When Dealing with Bills in Collections

When speaking to a provider:

"I'd like to work directly with you to pay my medical bills. Please pull the bill back from collection."

"I haven't been screened for charity care or financial assistance programs—I was improperly placed in collection."

"Can I pay you directly for my medical care rather than working with the collection agency?"

When speaking to a collection agency:

"Would you consider settling the bill for $_____?" (name a discounted price)

"I am currently working with my [insurance company]/[medical provider] to deal with these bills—please put my account on hold and do not ruin my credit while I [look into payment options]/[make an appeal]/[submit an application]"

"If I pay off this bill, will you contact the three credit bureaus to remove the account from my credit report?"

Contact the medical provider or hospital

Under the IL Fair Patient Billing Act, hospitals must give the patient at least 60 days following discharge to submit an application for financial assistance. Illinois hospitals may not take legal actions against uninsured patients for non-payment of a hospital bill if the patient shows that they do not have the income or assets to meet their financial obligations. This protection applies to patients who have cooperated with the hospital by providing all of the requested financial and other documentation needed to determine the patient's eligibility for financial assistance within 30 days of a request for this information. The patients is also responsible for informing the hospital of any change in their financial situation, within 30 days of the change, if it may affect their ability to abide by the provisions of an agreed upon reasonable payment plan or qualification for financial assistance.

Hospitals may not send the bill of an insured patient to collection without first offering, within 30 days of the initial bill, the opportunity to establish a reasonable payment plan for the amount owed by the patient.

MEDICAL BILLS ON CREDIT REPORTS

Very few medical providers directly report patients' unpaid bills to credit bureaus. However, many providers contract with collection agencies that do so. In 2003, the Federal Reserve found that 52% of collection accounts on Americans' credit reports were from medical bills. Medical debt can significantly damage a person's credit, which drives up interest rates and makes it difficult to access loans, credit cards, or other forms of credit. Negative marks on a credit report can even make it difficult to rent an apartment or, in some instances, get a job. Poor credit is one of the main road blocks preventing individuals and families from developing assets and bettering themselves financially.

People who have been contacted by collection agencies about medical bills are likely to have medical bills on their credit reports. Many people are not aware that medical debt has hurt their credit, especially if the debt is old. When a person's credit is ruined, the effects are long-term. Negative marks on a person's credit report can remain there for up to seven years.

The Access Project believes that medical debt should not appear on credit reports in most cases. Nevertheless, current law allows medical providers and collection agencies to report medical debt to credit bureaus and ruin peoples' credit. However, some medical debts may appear in error.

Medical Debt on Credit Reports

There are a number of techniques that people can use to remove medical debt from their credit reports, or reduce its detrimental effect on their financial security:

a) Identify and dispute illegitimate medical debt collections accounts.
   - See sample letters: "Verification and Dispute Letter to Credit Bureau—Illegitimate Medical Debt," "Verification and Dispute Letter to Credit Bureau—someone else's information," and "Verification and Dispute Letter to Collection Agency."

b) Negotiate with the collection agency or medical provider to deal with the unpaid bill and remove it from the credit report
   - See sections on "Negotiating Medical Bills" and "Medical Bills in Collection."

c) Identify and dispute legitimate medical debt collection accounts
   - See sample letters: "Verification and Dispute Letter to Credit Bureau—Consumer Statement," and "Verification and Dispute Letter to Collection Agency."

Please see the Federal Trade Commission brochure in this section for more information on challenging the accuracy of credit reports, "FTC Facts For Consumers: How to Dispute Credit Report Errors."

Accessing Credit Reports

There are three main credit bureaus: Equifax, Experian, and TransUnion. Consumers can get one free credit report each year from each of the three credit bureaus through www.annualcreditreport.com. People can also access a free credit report if they are on public assistance, unemployed but expect to apply for employment within 60 days, currently disputing inaccurate information, or are a victim of identity theft and have a Fraud Alert on file.

For additional information on consumer protections, visit the IL Office of Attorney General website at http://www.illinoisattorneygeneral.gov/consumers/free_creditrpt.html and see the brochure at the end of this section, "The Savvy Consumer's Checklist-How to Obtain a Free Credit Report."

FTC Facts
For Consumers
October 2011
focuson CREDIT
Federal Trade Commission
For The Consumer
ftc.gov ■ 1-877-ftc-help

How to Dispute Credit Report Errors

Your credit report contains information about where you live, how you pay your bills, and whether you've been sued or arrested, or have filed for bankruptcy. Credit reporting companies sell the information in your report to creditors, insurers, employers, and other businesses that use it to evaluate your applications for credit, insurance, employment, or renting a home. The federal Fair Credit Reporting Act (FCRA) promotes the accuracy and privacy of information in the files of the nation's credit reporting companies.

Some financial advisors and consumer advocates suggest that you review your credit report periodically. Why?

- Because the information it contains affects whether you can get a loan — and how much you will have to pay to borrow money.
- To make sure the information is accurate, complete, and up-to-date before you apply for a loan for a major purchase like a house or car, buy insurance, or apply for a job.
- To help guard against identity theft. That's when someone uses your personal information — like your name, your Social Security number, or your credit card number — to commit fraud. Identity thieves may use your information to open a new credit card account in your name. Then, when they don't pay the bills, the delinquent account is reported on your credit report. Inaccurate information like that could affect your ability to get credit, insurance, or even a job.

How to Order Your Free Report

The FCRA requires each of the nationwide credit reporting companies — Equifax, Experian, and TransUnion — to provide you with a free copy of your credit report, at your request, once every 12 months. For details, see *Your Access to Free Credit Reports* at **ftc.gov/credit**.

The three nationwide credit reporting companies have set up one website, toll-free telephone number, and mailing address through which you can order

your free annual report. To order, visit **annualcreditreport.com**, call 1-877-322-8228, or complete the Annual Credit Report Request Form and mail it to: Annual Credit Report Request Service, P.O. Box 105281, Atlanta, GA 30348-5281. You can use the form in this brochure, or you can print it from **ftc.gov/credit**. Do not contact the three nationwide credit reporting companies individually. They are providing free annual credit reports only through **annualcreditreport.com**, 1-877-322-8228, and Annual Credit Report Request Service, P.O. Box 105281, Atlanta, GA 30348-5281.

The law allows you to order one free copy of your credit report from each of the nationwide credit reporting companies every 12 months.

You may get your free reports from each of the three nationwide credit reporting companies at the same time, or from only one or two. The FCRA allows you to get one free report from each of the nationwide credit reporting companies every 12 months.

You need to provide your name, address, Social Security number, and date of birth. If you have moved in the last two years, you may have to provide your previous address. To maintain the security of your file, each nationwide credit reporting company may ask you for some information that only you would know, like the amount of your monthly mortgage payment. Each company may ask you for different information because the information each has in your file may come from different sources.

Other situations where you might be eligible for a free report

You're also entitled to a free report if a company takes adverse action against you, such as denying your application for credit, insurance, or employment, based on information in your report. You must ask for your report within 60 days of receiving notice of the action. The notice will give you the name, address, and phone number of the credit reporting company.

You're also entitled to one free report a year if you're unemployed and plan to look for a job within 60 days; if you're on welfare; or if your report is inaccurate because of fraud, including identity theft.

Otherwise, a credit reporting company may charge you up to $11.00 for another copy of your report within a 12-month period. To buy a copy of your report, contact:

Experian - 1-888-397-3742; **experian.com**

TransUnion - 1-800-916-8800; **transunion.com**

Equifax - 1-800-685-1111; **equifax.com**

For details, see *Your Access to Free Credit Reports* at **ftc.gov/credit**.

Correcting Errors

Under the FCRA, both the credit reporting company and the information provider (that is, the person, company, or organization that provides information about you to a credit reporting company) are responsible for correcting inaccurate or incomplete information in your report. To take advantage of all your rights under this law, contact the credit reporting company and the information provider.

Step One

Tell the credit reporting company, in writing, what information you think is inaccurate. Include copies (NOT originals) of documents that support your position. In addition to providing your complete name and address, your letter should clearly identify each item in your report you dispute, state the facts and explain why you dispute the information, and request that it be removed or corrected. You may want to enclose a copy of your report with the items in question circled. Your letter may look something like the one on page 4. Send your letter by certified mail, "return receipt requested," so you can document what the credit reporting company received. Keep copies of your dispute letter and enclosures.

Credit reporting companies must investigate the items in question — usually within 30 days — unless they consider your dispute frivolous. They also must forward all the relevant data you provide about the inaccuracy to the organization that provided the information. After the information provider receives notice of a dispute from the credit reporting company, it must investigate, review the relevant information, and report the results back to the credit reporting company. If the information provider finds the disputed information is inaccurate, it must notify all three nationwide credit reporting companies so they can correct the information in your file.

When the investigation is complete, the credit reporting company must give you the results in writing and a free copy of your report if the dispute results in a change. This free report does not count as your annual free report. If an item is changed or deleted, the credit reporting company cannot put the disputed information back in your file unless the information provider verifies that it is accurate and complete. The credit reporting company also must send you written notice that includes the name, address, and phone number of the information provider.

If you ask, the credit reporting company must send notices of any corrections to anyone who received your report in the past six months. You can have a corrected copy of your report sent to anyone who received a copy during the past two years for employment purposes.

When the investigation is complete, the consumer reporting company must give you the results in writing and a free copy of your report if the dispute results in a change.

If an investigation doesn't resolve your dispute with the credit reporting company, you can ask that a statement of the dispute be included in your file and in future reports. You also can ask the credit reporting company to provide your statement to anyone who received a copy of your report in the recent past. You can expect to pay a fee for this service.

Step Two

Tell the creditor or other information provider, in writing, that you dispute an item. Be sure to include copies (NOT originals) of documents that support your position. Many providers specify an address for disputes. If the provider reports the item to a credit reporting company, it must include a notice of your

dispute. And if you are correct — that is, if the information is found to be inaccurate — the information provider may not report it again.

About Your File

Your credit file may not reflect all your credit accounts. Although most national department store and all-purpose bank credit card accounts will be included in your file, not all creditors supply information to credit reporting companies: some local retailers, credit unions, and travel, entertainment, and gasoline card companies are among the creditors that don't.

When negative information in your report is accurate, only the passage of time can assure its removal. A credit reporting company can report most accurate negative information for seven years and bankruptcy information for 10 years. Information about an unpaid judgment against you can be reported for seven years or until the statute of limitations runs out, whichever is longer. There is no time limit on reporting: information about criminal convictions; information reported in response to your application for a job that pays more than $75,000 a year; and information reported because you've applied for more than $150,000 worth of credit or life insurance. There is a standard method for calculating the seven-year reporting period. Generally, the period runs from the date that the event took place.

For more information, see *Building a Better Credit Report* at **ftc.gov/credit**.

Sample Dispute Letter

Date
Your Name
Your Address,
City, State, Zip Code

Complaint Department
Name of Company
Address
City, State, Zip Code

Dear Sir or Madam:

I am writing to dispute the following information in my file. I have circled the items I dispute on the attached copy of the report I received.

This item (identify item(s) disputed by name of source, such as creditors or tax court, and identify type of item, such as credit account, judgment, etc.) is (inaccurate or incomplete) because (describe what is inaccurate or incomplete and why). I am requesting that the item be removed (or request another specific change) to correct the information.

Enclosed are copies of (use this sentence if applicable and describe any enclosed documentation, such as payment records and court documents) supporting my position. Please reinvestigate this (these) matter(s) and (delete or correct) the disputed item(s) as soon as possible.

Sincerely,
Your name

Enclosures: (List what you are enclosing.)

EQUIFAX® experian® TransUnion®

Annual Credit Report Request Form

You have the right to get a free copy of your credit file disclosure, commonly called a credit report, once every 12 months, from each of the nationwide consumer credit reporting companies - Equifax, Experian and TransUnion.

For instant access to your free credit report, visit www.annualcreditreport.com.

For more information on obtaining your free credit report, visit www.annualcreditreport.com or call 1-877-322-8228.

Use this form if you prefer to write to request your credit report from any, or all, of the nationwide consumer credit reporting companies. The following information is required to process your request. **Omission of any information may delay your request.**

Once complete, fold (do not staple or tape), place into a #10 envelope, affix required postage and mail to:

Annual Credit Report Request Service P.O. Box 105281 Atlanta, GA 30348-5281.

Please use a Black or Blue Pen and write your responses in PRINTED CAPITAL LETTERS without touching the sides of the boxes like the examples listed below:

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 0 1 2 3 4 5 6 7 8 9

Social Security Number: ___ - ___ - ____

Date of Birth: ___ / ___ / ____

Month / Day / Year

Fold Here

Fold Here

First Name | **M.I.**

Last Name | **JR, SR, III, etc.**

Current Mailing Address:

House Number | **Street Name**

Apartment Number / Private Mailbox | **For Puerto Rico Only: Print Urbanization Name**

City | **State** | **ZipCode**

Previous Mailing Address (complete only if at current mailing address for less than two years):

House Number | **Street Name**

Fold Here

Fold Here

Apartment Number / Private Mailbox | **For Puerto Rico Only: Print Urbanization Name**

City | **State** | **ZipCode**

Shade Circle Like This → ●

Not Like This → ⊗ ✓

I want a credit report from (shade each that you would like to receive):

- ◯ **Equifax**
- ◯ **Experian**
- ◯ **TransUnion**

◯ **Shade here if, for security reasons, you want your credit report to include no more than the last four digits of your Social Security Number.**

If additional information is needed to process your request, the consumer credit reporting company will contact you by mail.

Your request will be processed within 15 days of receipt and then mailed to you.

31238

The FTC works to prevent fraudulent, deceptive and unfair business practices in the marketplace and to provide information to help consumers spot, stop and avoid them. To file a complaint or get free information on consumer issues, visit **ftc.gov** or call toll-free, 1-877-FTC-HELP (1-877-382-4357); TTY: 1-866-653-4261. Watch a video, *How to File a Complaint,* at **ftc.gov/video** to learn more. The FTC enters consumer complaints into the Consumer Sentinel Network, a secure online database and investigative tool used by hundreds of civil and criminal law enforcement agencies in the U.S. and abroad.

Federal Trade Commission
Bureau of Consumer Protection
Division of Consumer and Business Education

LISA MADIGAN
ILLINOIS ATTORNEY GENERAL

The Savvy Consumer's Checklist
How to Obtain a Free Credit Report

Under a new federal law, all Illinoisans can receive free copies of their credit reports once a year from each of the three national credit reporting agencies–Equifax, Experian, and Trans Union. The annual free reports are available only through the centralized source set up by the three credit reporting agencies. If consumers contact the companies directly they will still be charged for their credit reports.

Please note that when you apply for your free credit reports, the credit reporting agencies will likely attempt to sell you upgraded services for a fee. You are under no obligation to purchase any upgraded services; instead, you may simply say no to these options and receive only your free report.

To obtain the free reports, consumers can:

- ✓ **Call 1-877-322-8228;**
- ✓ **Order online at www.annualcreditreport.com;** or
- ✓ **Complete the Annual Credit Report Request Form,** available at www.ftc.gov/credit, and mail it to: Annual Credit Report Request Service, P.O. Box 105281, Atlanta, GA 30348-5281.

To maximize the benefits of this new law, consumers should consider ordering one report from one agency at a time, at four-month intervals.

Additional Free Reports for:

Victims of Identity Theft
In addition to the free reports available each year, consumers are entitled to a free report from each of the agencies if they believe they have become the victim of identity theft. To receive the free report in these circumstances, victims should contact each reporting agency directly and be prepared to provide a copy of a police report.

When an Application for Credit is Denied
Consumers also are entitled to a free credit report if their applications for credit have been denied based on information provided by a reporting agency. On these occasions, consumers must contact the reporting agencies directly and make their requests within 30 days after the application for credit was denied.

Consumers also should be aware that www.annualcreditreport.com and the national credit reporting companies will never send consumers e-mails asking for personal or financial information. Any e-mail that claims to be from one of these agencies should be considered a scam.

Please visit www.IllinoisAttorneyGeneral.gov

Chicago
100 West Randolph Street
Chicago, IL 60601
(312) 814-3000
TTY: (312) 814-3374

Springfield
500 South Second Street
Springfield, IL 62706
(217) 782-1090
TTY: (217) 785-2771

Carbondale
1001 East Main Street
Carbondale, IL 62901
(618) 529-6400/6401
TTY: (618) 529-6403

Spanish Language Hotline
1-866-310-8398

ADDITIONAL ILLINOIS AND NATIONAL RESOURCES

Advocacy Organizations

The Illinois Campaign for Better Health Care
http://www.cbhconline.org/

Campaign for Better Health Care
44 E. Main Street, Suite 414
Champaign, IL 61820
217 352-5600

Campaign for Better Health Care
1325 S. Wabash Avenue, Suite 305
Chicago, IL 60605
312 913-9449

The Illinois Campaign for Better Health Care is a grassroots coalition of more than 300 local and statewide organizations representing consumers, health care workers and providers, community organizations, seniors, religious, labor, disability rights organizations and other citizens concerned about health care and wellness. Its mission is that accessible, affordable, quality health care is a basic human right for ALL people.

Legal Assistance

Legal Assistance Foundation of Metropolitan Chicago
http://www.lafchicago.org

Legal Assistance Foundation of Metropolitan Chicago
120 S. LaSalle Street, Ste. 900
Chicago, IL 60603
312 341-1070

The Legal Assistance Foundation (LAF) of Metropolitan Chicago provides civil legal services to low-income and disadvantaged people and communities. Their mission is to use advocacy, education, collaboration and litigation to empower individuals, protect fundamental rights, strengthen communities, create opportunities and achieve justice. In carrying out their mission, they strive to treat all people with compassion and respect.

The LAF helps people apply for and maintain public benefits, including Medicaid, Medicare Part D prescription drug benefits, and they also people who are uninsured reduce or eliminate bills from not-for-profit hospitals.

ADDITIONAL ILLINOIS AND NATIONAL RESOURCES

Provider Organizations

The Illinois Primary Health Care Association (IPHCA)
http://www.iphca.org/Home.aspx

Springfield Office
500 S. Ninth St.
Springfield, IL 62701

Chicago Office
542 S. Dearborn St., Suite 300
Chicago, IL 60605

The Illinois Primary Health Care Association is a nonprofit trade association of Illinois community health centers. It represents 45 community health centers that operate over 450 sites in the state of Illinois. Its mission is to improve the health status of medically underserved populations by fostering the provision of high-quality, comprehensive health care that is accessible, coordinated, community-directed, culturally sensitive, and linguistically competent.

The Illinois Hospital Association
http://www.ihatoday.org/

IHA Headquarters
1151 East Warrenville Rd.
P.O. Box 3015
Naperville, IL 60566
(630) 276.5400

Springfield Office
700 South 2nd Street
Springfield, IL 62704
(217) 541.1150

The IHA vision for Illinois health care is that all individuals and communities deserve access to high quality health care at the right time and in the right setting to support each person's quest for optimum health. Its mission is to advocate for and support hospitals and health systems as they serve their patients and communities.

Cook County Bureau of Health Services
http://www.cchil.org/dom/bureau.html
Department of Medicine
Administration Building, 15th Floor
1900 W. Polk St., Chicago, IL 60612
(312) 864 - 7203

The Cook County Bureau of Health Services. provides care, education, and prevention training at health centers, clinics, schools, hospitals, and other sites throughout Chicago and suburban Cook County. The Bureau offers a comprehensive range of services from preventive and primary care to emergency/trauma, acute, rehabilitation, and long-term care.

Provider Organizations (con't)

The New Cook County Hospital (John H. Stroger, Jr. Hospital)
http://www.cchil.org/dom/cook.html

John Stroger Hospital
1900 W. Polk St.
Chicago, IL 60612
(312) 864-6000

John Stroger Hospital, the new Cook County Hospital, is the state-of-the-art, which serves as the hospital and care hub of the Cook County Bureau of Health Services system. The new hospital facility continues the tradition of community-focused hospital care that began in 1866, when the first county-owned hospital building was opened.

Access Community Health Network (ACCESS)
http://www.accesscommunityhealth.net/about

Access Community Health Network
222 North Canal Street
Chicago, IL 60606
(866) 882.2237

Access Community Health Network (ACCESS) offers primary and preventive care in more than 50 community health center locations throughout Chicago and the surrounding suburbs. Its mission is to provide outstanding preventive and primary health care, accessible to all in their own communities.

CommunityHealth Free Clinic
http://www.communityhealth.org/

West Town Location
2611 W. Chicago Ave.
Chicago, IL 60622
(773) 395-9900

Englewood Location
641 West 63rd Street
Chicago, IL 60621
(773) 994-1515

CommunityHealth services Chicago area residents without adequate health insurance. It mission is to be the leader in delivering comprehensive, high-quality, patient-centered health care at no cost to low-income, uninsured individuals in need of a medical home.

ADDITIONAL ILLINOIS AND NATIONAL RESOURCES

For More Information on the Affordable Care Act

http://www.healthcare.gov/

Healthcare.gov is a website that helps consumers to take control of their health care options by connecting them with new information and resources that can help them obtain access to affordable, quality health care. Visit the site to find information about your health insurance options, prevention, specifics of the new law, implementation, and information for different types of health care consumers (families with children, young adults, those with disabilities, and more).

http://Cuidadodesalud.gov

Cuidadodesalud.gov es un sitio de Internet en español que ayuda a los consumidores, específicamente los hispanohablantes, a tomar el control de su cuidado de salud al conectarlos con nueva información y recursos que los ayudarán a obtener acceso a seguro médico económico y de calidad. Visite el sitio de Web para encontrar información sobre sus opciones de seguro, prevención, la nueva ley, implementación, y información para diferentes tipos de consumidores (familias con niños, jóvenes, discapacitados y más)

Children's Memorial Hospital
2300 Children's Plaza | Chicago, IL | 60614-3363 | (773) 880-4000
www.childrensmemorial.org

- Has link for "About Financial Assistance" from home page
- Help with All Kids Enrollment and will refer eligible families to the Division of Specialized Care for Children
- Online financial assistance text:

Financial assistance

For more information, call 773.880.4273 or toll-free at 877.924.8200.

We know some patients and families will require financial assistance in paying for health care. Children's Memorial can provide assistance in the following ways:

- *Assist in the completion of a public aid application (MANG) for inpatients.*
- *Help outpatient families complete an All Kids application. All Kids is low-cost or free health insurance for Illinois children that covers check-ups, medications, doctor visits and more.*
- *Refer eligible families to the Division of Specialized Care for Children.*
- *Connect with various social service organizations, such as Women, Infants and Children (WIC).*
- *Initiate sliding scale arrangements and/or payment plans for deductibles, coinsurance and any other patient responsibility balances.*
- *Offer financial assistance and charity care based on documented need.*
- *Offer a discount to patients without insurance who meet certain criteria and provide help for uninsured patients facing a significant financial burden.*

To apply for the hospital's financial assistance program, families must cooperate in identifying, applying for and procuring all available payment resources. For more information, call 773.880.4273 or 877.924.8200. Or in the hospital, visit the Admitting Department, room M126, on the first floor.

Find information here on Health and Human Services Federal Poverty guidelines.

Children's Memorial Hospital
Where kids come first.

Financial assistance

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Children's Memorial Hospital (childrensmemorial.org)
2300 Children's Plaza Chicago, Illinois 60614-3363 773.880.4000 1.800.KIDS DOC

FINANCIAL APPLICATION
PATIENT FINANCIAL SERVICES
2300 CHILDREN'S PLAZA, BOX #44
CHICAGO, ILLINOIS 60614
TELEPHONE: 877. 924.8200
FAX: 312. 573.4598

PATIENT NAME: _____ **DATE:** _____

PATIENT'S DATE OF BIRTH: _____

GUARANTOR NAME: _____ **ACCOUNT #:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

To better help you meet your financial responsibilities, it is necessary that you complete the Financial Application in its entirety. Please submit the application with the requested documents. For a list of documents, please refer to the second page.

PERSONAL INFORMATION	
Mother's Name:	Mother's Occupation:
Father's Name:	Father's Occupation
Patient's Name:	Patient's Occupation:
Legal Guardian's Name:	Guardian's Occupation:
Number of Dependents:	
ASSETS AND INCOME	
Assets:	Monthly Income:
Savings:	Father:
Checking:	Mother:
Other:	Other:
	Child Support:
	Social Security:
Total:	Total
NET MONTHLY EXPENSES FOR NECESSITIES	
Rent:	Electricity:
Mortgage:	Gas:
Group/Private Health Insurance Premiums:	Telephone:
House/Rental Insurance:	Water:
Other:	Food Payment: (average)

Car Payments # of Vehicles:	Child Care/School Tuition:
Car Insurance:	Transportation: (CTA, PACE, METRA)
	Total Monthly Expenses:

LIST MEDICAL EXPENSES INCURRED DURING THE PAST 12 MONTHS

Hospital/Physician	**Current Balance**	**Total Debt**
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER EXPENSES

Description	**Monthly Payment**	**Balance**
_____	_____	_____
_____	_____	_____
_____	_____	_____

In order for Children's Memorial Hospital to help you meet your financial needs, please include last year's income tax returns (e.g. W2 and 1040), paycheck stubs for each parent who is employed for past 3 months (or a letter from the employer if paid in cash), and supporting documents for other income. I

I certify that to the best of my knowledge all information is true and correct.

Signature: _____ Date: _____

Reminder: This Financial Application must be completed in order to give consideration for financial assistance. If you need assistance completing this form, please contact Customer Service at 877. 924.8200.

03-05
Revised 05-07

All Kids Premiums and Out-of-Pocket Costs Vary by Monthly Income and Family Size

To find out how much All Kids may cost you, follow these 4 simple steps:

1) Find your family size in the column "Family Size." Be sure to count yourself.
2) Look only at your family size row. Read across that row to the box where your family's total monthly gross income falls.
3) The box will be in the column of the All Kids plan that matches your income.
4) Read down that column to the cost box at the bottom. The cost box shows the Monthly Premium per child, along with the maximum Monthly Premium for your family, and the Maximum Co-Payments per child, per year.

INCOME BOX*

Family Size	All Kids Assist	All Kids Share	All Kids Premium Level 1	All Kids Premium Level 2	All Kids Premium Level 3	All Kids Premium Level 4	All Kids Premium Level 5-7	All Kids Premium Level 8
1	Up to $1,200 per month	$1,201 - 1,354 per month	$1,355 - 1,805 per month	$1,806 - 2,708 per month	$2,709 - 3,610 per month	$3,611 - 4,513 per month	$4,514 - 7,220 per month	$7,221 or more per month
2	Up to $1,615 per month	$1,616 - 1,821 per month	$1,822 - 2,428 per month	$2,429 - 3,643 per month	$3,644 - 4,857 per month	$4,858 - 6,071 per month	$6,072 - 9,713 per month	$9,714 or more per month
3	Up to $2,029 per month	$2,030 - 2,289 per month	$2,290 - 3,052 per month	$3,053 - 4,578 per month	$4,579 - 6,103 per month	$6,104 - 7,629 per month	$7,630 - 12,207 per month	$12,208 or more per month
4	Up to $2,444 per month	$2,445 - 2,756 per month	$2,757 - 3,675 per month	$3,676 - 5,513 per month	$5,514 - 7,350 per month	$7,351 - 9,188 per month	$9,189 - 14,700 per month	$14,701 or more per month
5	Up to $2,858 per month	$2,859 - 3,224 per month	$3,225 - 4,298 per month	$4,299 - 6,448 per month	$6,449 - 8,597 per month	$8,598 - 10,746 per month	$10,747 - 17,193 per month	$17,194 or more per month

COST BOX

Monthly Premium per child	None	None	1 child: $15 2 children: $25 Ea. add'l child: $5	$40 per child	$70 per child	$100 per child	$150 - 250 per child	$300 per child
Max Monthly Premium	N/A	N/A	$40 for 5 or more children	$80 for 2 or more children	$140 for 2 or more children	$200 for 2 or more children	No Cap	No Cap
Max Co-Payments per Year	No co-payments	$100 per family for all services	$100 per family for all services	$500 per child for hospital services	$750 per child for hospital services	$1,000 per child for hospital services	$5,000 per child for hospital services	No Max

*Income levels for 2010.

HFS 3711AK (R-6-10)

www.AllKids.com

1-866-ALL-KIDS (1-866-255-5437) | (TTY: 1-877-204-1012)

Franciscan St. James Health

1423 Chicago Road | Chicago Heights, Illinois 60411 | (708) 709-1000
www.stjameshospital.org

- No link for financial assistance from home page; used search engine for "financial assistance" and "charity care" (both worked for Billing and Insurance page)
- Must call to learn more about financial assistance programs.
- Online Billing and Insurance text:

Billing and Insurance

Franciscan St. James Health accepts most major insurance plans. If you have any questions about your coverage or its applicability to Franciscan St. James services, please contact your company's representatives.

Franciscan St. James will bill your health plan on your behalf, including Medicare and Medicaid, for payment of hospital services. If you have more than one health plan, Franciscan St. James will also bill these additional carriers. However, it is important to remember that you are ultimately responsible for payment of your hospital bill.

Many insurance companies require proper authorization, pre-certification and/or referrals. It is your responsibility to know what your insurance company requires and to obtain the proper authorization. Franciscan St. James may ask you to pay any unmet deductibles, co-payments or other self-pay amounts that are due, prior to the time of service or prior to discharge.

If you do not have health insurance, or if you are experiencing financial difficulties on your portion of the bill and you anticipate that you may not be able to pay your bill, Franciscan St. James offers hospital financial assistance programs. Based on your income, assets and needs, Franciscan St. James Financial Counselors may help you qualify for hospital Charity Care or Uninsured Patient Discounts for medically necessary healthcare services. In addition, Franciscan St. James Financial Counselors may help you apply for government assistance programs or work with you to create an alternative payment plan.

Our Financial Counselors can be reached at (708) 756-5254, Monday through Friday, 8:00 a.m. to 5:00 p.m. should you have any questions about payments for services.

Holy Cross Hospital

2701 West 68th Street | Chicago, IL 60629 | (773) 884-9000 | www.holycrosshospital.org
Financial Counselor (800) 495-4227

- Has link for "Financial Assistance" from home page
- Has a financial assistance application online in English/Spanish
- Online financial assistance text:

Financial Assistance
You may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients. For more information contact hospital financial assistance representatives at 1-800-495-4227.

HCH Financial Assistance Application.pdf

E-mail Financial Assistance: financialassistance@holycrosshospital.org

2701 West 68th Street
Chicago IL 60629
1-800-495-4227

PATIENT INFORMATION/INFORMACION DEL PACIENTE

Patient Name/Nombre del Paciente	Account Balance/Balancia de Cuenta	Patient Number/Numero del Paciente	Date of Birth/Fetcha de Nacimiento
Admission Date/Fecha De Entrada	Discharge Date/Fecha De Despedida	Social Security #/Num de Seguro Social	Marital Status/Estado Civil
Home Address/Direccion De Residencia			
City/Ciudad		State/Estado	ZIP/Codigo Postal
Name of Medical Provider/Nombre Del Proveedor De Sercisios Medicos		Beginning Coverage Date/Fecha del Comienzo	
Name of Doctor/Nombre Del Medico			
Employer Name/Nombre de Empleador		Occupation/Ocupacion	Telephone/Telefono

GUARANTOR INFORMATION/PERSONA RESPONSABLE

Name/Nombre		Social Security #/Num de Seguro Social	Age/Edad
Relationshipto Applicant/Relacion con el Paciente	Address/Direccion		Telephone/Telefono
City/Ciudad		State/Estado	ZIP/Codigo Postal
Employer/Empleador		Employer Phone/Number De Empleador	Occupation/Occupacion
Address/Direccion			
City/Ciudad		State/Estado	ZIP/Codigo Postal

FINANCIAL INFORMATION/INFORMATION FINANCIAL

Total Monthly Income/Ingresos Mensuales	No. of Dependants/Cuantos Dependientes	Residence(Own/Rent) Casa Propia o Renta	Car (Model/Year)/Carro (Model/Ano)

RESOURCES/RECURSOS

Name of Bank/Nombre del Banco	Checking Account/Cueta de Cheques	Savings Account/Cuentas de Ahorros
	$	$

MONTHLY EXPENSES/GASTOS MENSUALES

Rent/Mortgage Payment Payment/Renta o Pago Hipotecario	Water Bill/Pago de Agua	Gas Bill/Pago de Gas	Phone Bill/Cuenta De Telefono
$	$	$	$
Electric Bill;/Pago de Electricidad	Car Payment/Pago de Carro	Insurance Premium/Pago de Prima	Other Bills/Otro Gastos
$	$	$	$

HOUSEHOLD COMPOSITION/INFORMACION DE LA CASA

Name/Nombre	Relationship/Relacion con el Paciente	Date of Birth/Fecha de Nacimiento	Social Security No. Num de Seguro Social

If unable to provide requested documents, please explain below/
Por favor de dar una explicacion si no es possible proveer los documentos.

COMMENTS/COMETARIOS

AFFIDAVIT/DECLARACION JURADA

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge. I agree to tell the provider of service within ten (10) days if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses, or in the persons household, or any change of address. I understand that I may be asked to prove my statements and my eligibility statements will be subject to verification by contact with my employer, bank credit verification and property searches. I understand the county is required by law to keep any information I provide confidential. I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county from the proceeds of litigation or settlement resulting from such an act.	Declaro bajo pena de perjuria que las respuestas que he dado son verdaderas y correctas al major de mi conocimiento. Acuerdo decirle al abastecedor del servicio en el plazo de diez dias si hay algunos cambios en mi (o personas en el favor que yo este actuando) renta, propiedad, gastos, o en la casade las personas, o cualquier cambio de direccion. Entiendo que puedo ser pedido probar mis declaraciones de la elegibilidad estaran conforme a la verificacion al lado de contacto con mi patron, verificacion del credito de banco y busquedas de propiedad. Entiendo queel condado es requerido por ley de ptoejer cualquier informacion que yo proporcione confidencial. Tambien convengo, en la consideracion de recibir servicios del cuidado medico como resultado de un accidente o lesion, de tener que reembolsarle al condado de los ingresos de la demanda o cualquier resultado de tal acto.

_____ _____

Signature/Firma Date/Fecha

For Hospital Use Only/Uso Solamente Para el Hospital

Facility/Facilidad: _____ **Accepted/Aceptar**: _____ **Denied/Negacion**: _____

COMMENTS/COMETARIOS:

_____ _____

Signature Approval **Date**

La Rabida Children's Hospital

326 West 64th Street | Chicago, IL 60621 | (773) 962-3900 | www.stbh.org
Patient Financial Services: (773) 753-8678

- Has link for "Patient Financial Assistance" from the home page
- Has link to Download Charity Care Application form .pdf
- Online financial assistance text:

Patient Financial Assistance

La Rabida offers financial assistance to patients who qualify. With the application process, decisions will be communicated by mail or telephone within 10 days of the hospital's receipt of your completed application.

The Process-*Eligibility is determined using the Financial Assistance Application. Print, complete and submit the form to request a review of your eligibility for assistance. The application is also available for pick-up at the hospital's Patient Financial Services Department. Mapquest directions here.*

Patient Financial Services

- *Make financial assistance inquiries*
- *Request a Financial Assistance Application*
- *Seek assistance in completing the form*

Form submission-*Mail the completed form and all required documentation to:*

La Rabida Children's Hospital,
Patient Financial Services
Attn: Financial Assistance Representative
East 65th Street at Lake Michigan
Chicago, Illinois 60649

Contact Us-*For additional details, call Patient Financial Services at 773.753.8678, 9:00 a.m. to 4:00 p.m., Monday through Friday.*

La Rabida Children's Hospital

East 65th Street at Lake Michigan
Chicago, IL 60649
P: 773.363.6700

LA RABIDA
CHILDREN'S HOSPITAL

Financial Assistance Application

Patient's Name .....

Address .....

City State Zip code

Telephone (.....).....

Patient Account Number ....

Date of Service ....

Amount Due ....

Responsible Person's Name .....

Address .....

(If address information is same as patient, indicate same) City State Zip code

Relationship to Patient .....

Provide health insurance information, if covered

Insurance Company's Name .....

Address .....

City State Zip code

Telephone (.....).....

Name of Subscriber .....

Group and Policy Numbers .....

Effective Dates ...../...../..... - ...../...../.....

Do you have coverage through the Illinois Department of Healthcare & Family Services (Public Aid) or have you applied for aid including coverage through Kid Care? Yes ☐ No ☐

How many family members in the household? .....

Is any adult member of the family unable to work due to injury or illness? Yes ☐ No ☐

If yes, please explain .....

.....

Identify members of the household who are employed

Name of Employed Members .....
Occupation .....
Monthly Income .....
Number of Years Employed .....

List names and ages of dependents below

How many dependents are being supported? .....

Name of Dependent .....
Date of Birth .....
Name of Dependent .....
Date of Birth .....

(Use a separate sheet to list additional dependents.)

Is the household receiving any money as a result of child support payments, alimony, Social Security income or any other income? Yes ☐ No ☐
If "Yes" indicate source of income and monthly dollar amount: $ .....

List medical or financial problems within the household .....
.....

Do you expect to receive payment for these services from any other source including accident or liability coverage?
Yes ☐ No ☐

Proof of income must be provided. Attach most recent income tax return form and/or the most recent 4 weeks of pay stubs. If receiving Social Security benefits or any other income in addition to the above, attach copies.

Responsible Person's Signature ..... DATE ...../...../.....

Hospital Representative's Signature .....DATE ...../...../.....

FOR HOSPITAL USE ONLY

Patient's Name .....
City State
Number in Household .....
Annual Income $ ..... **Total Charges** $ .....

Verification of documentation received

Income Tax Form ..... **Pay Stubs** ..... **Other Income Verification** .....

Has the guarantor cooperated with all requests? Yes ☐ No ☐
Does the guarantor meet the Financial Assistance Guidelines? ..... Commets .....

Approved: Yes ☐ No ☐ Approved Amount: $ .....

Patient Accounts Manager ..... DATE ...../...../.....

VP Admin & CFO .....DATE ...../...../.....

Mercy Hospital and Medical Center

2525 South Michigan Avenue |Chicago, IL 60616-2477 |(312) 567-2000
www.mercy-chicago.org

- Has link for "Financial Assistance" from the home page
- Has link to Financial Assistance form .pdf
- Has link to Federal Poverty Guidelines
- Is an All Kids Enrollment site
- Online financial assistance text:

Our Commitment-*Mercy Hospital is committed to providing quality healthcare to our entire community. As part of that commitment, if you receive care at Mercy Hospital and are uninsured, underinsured, or insured but unable to meet your co-payment requirements, our financial counselors are available to assist you with the identification of a financial assistance program to meet your needs. Patients who are unable to pay their bills may be eligible for programs designed to assist families in need including Medicaid, Medicare and social security insurance disability, or for one of Mercy's comprehensive financial assistance programs.*

Financial Assistance Programs at Mercy-Mercy offers comprehensive financial assistance options to help patients who are unable to pay their hospital services bill. These programs options include:

Time Payment Program *that offers patients who are unable to pay their balance at one time an extended payment plan arrangement.*

Limited Income Discount Program *that offers a discount based on family size and household income.*

Self-Pay Discount Program *that offers a 40% discount to patients who are uninsured but do not meet eligibility requirements for other financial assistance programs.*

Charity Care Program *that offers care without expectation of payment for patients whose household income is less than 250% of the Federal Poverty Guidelines established by the Department of Health and Human Services.*

In addition to the above programs, Mercy is an ***All Kids Enrollment Site****, which means we provide assistance with All Kids application completion and submission. All Kids is a state-funded insurance program for children and Family Care, which provides affordable healthcare for parents of children 18 years or younger. We can also assist with the application process for other federal and state funded assistance programs including Medicaid, Medicare, and social security insurance disability.*

How Do I Participate? *To participate in Mercy's financial assistance programs, patients must meet certain eligibility criteria; eligibility requirements, terms and conditions vary for each financial assistance program. A Mercy financial counselor can help you understand each program more fully and your qualification for each program as well as assist you with the application process. Please note that as part of the application process, you will be required to provide us with certain personal and financial information in order to determine eligibility.*

To speak with a financial counselor, please call 312.567.2135 or 312.567.2438 or download a Request form for Determination of Charity Care Eligibility. Please note that Adobe Acrobat Reader is required to view the form and is available free of charge by visiting the Adobe website.

To learn about Mercy's billing policies, take advantage of online account manager resources, pay your bill online, or review your account online, visit ***online bill payment.***

Financial Assistance

Our Commitment

Mercy Hospital is committed to providing quality healthcare to our entire community. As part of that commitment, if you receive care at Mercy Hospital and are uninsured, underinsured, or insured but unable to meet your co-payment requirements, our financial counselors are available to assist you with the identification of a financial assistance program to meet your needs. Patients who are unable to pay their bills may be eligible for programs designed to assist families in need including Medicaid, Medicare and social security insurance disability, or for one of Mercy's comprehensive financial assistance programs.

Financial Assistance Programs at Mercy

Mercy offers comprehensive financial assistance options to help patients who are unable to pay their hospital services bill. These programs options include:

Time Payment Program that offers patients who are unable to pay their balance at one time an extended payment plan arrangement.

Limited Income Discount Program that offers a discount based on family size and household income.

Self-Pay Discount Program that offers a 40% discount to patients who are uninsured but do not meet eligibility requirements for other financial assistance programs.

Charity Care Program that offers care without expectation of payment for patients whose household income is less than 250% of the Federal Poverty Guidelines established by the Department of Health and Human Services.

In addition to the above programs, Mercy is an **All Kids Enrollment Site**, which means we provide assistance with All Kids application completion and submission. All Kids is a state-funded insurance program for children and Family Care, which provides affordable healthcare for parents of children 18 years or younger. We can also assist with the application process for other federal and state funded assistance programs including Medicaid, Medicare, and social security insurance disability.

How Do I Participate?

To participate in Mercy's financial assistance programs, patients must meet certain eligibility criteria; eligibility requirements, terms and conditions vary for each financial assistance program. A Mercy financial counselor can help you understand each program more fully and your qualification for each program as well as assist you with the application process. Please note that as part of the application process, you will be required to provide us with certain personal and financial information in order to determine eligibility.

To speak with a financial counselor, please call 312.567.2135 or 312.567.2438 or download a Request form for Determination of Charity Care Eligibility. Please note that Adobe Acrobat Reader is required to view the form and is available free of charge by visiting the Adobe website.

To learn about Mercy's billing policies, take advantage of online account manager resources, pay your bill online, or review your account online, visit **online bill payment.**

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR CHARITY CARE: FINANCIAL STATEMENT

I hereby request that Mercy Hospital & Medical Center make a written determination of my eligibility for Charity Care at the Medical Center for hospital-based services (non-professional fees). I understand that the information I provide concerning my family size and income is subject to verification by the Medical Center. I also understand that if the information is determined to be false, I will be liable for all charges for services that I receive.

1) Demographic Information

NAME: _____
First Middle Last

ADDRESS: _____
Number and Street

_____
City State ZIP

2) Employment Information

OCCUPATION: _____

EMPLOYER: _____

3) Income Information (Please Include your most recent W2)

	Total for Last 3 Months	Total for Last 12 Months
● Wages		
● Public Assistance		
● Social Security		
● Unemployment Comp.		
● Workmen's Compensation		
● Strike Benefits		
● Alimony		
● Child Support		
● Military Family Allotments		
● Pensions		
● Income from Dividends		
● Interest, Rent		
● Other		

4) Family Size Information

Total Number in Household: _____
(Number of Individuals for whom you are financially responsible)

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5) Type of Medical Service: _____

_____

_____

I affirm that the information that has been provided in this Financial Statement is true and correct to the best of my knowledge.

_____ ____/____/____
Signature of Person Making Request Date

_____ ____/____/____
Mercy Financial Counselor Date

II. Determination of Eligibility

1) INCOME
Total income for last 3 months $ _____ X 4 = $ _____

Total income for last 12 months $ _____

2) If the patient's statement of income was verified by the time the determination was made, stipulate exactly what information was used, the source (name and telephone number) of the person providing the information.

_____
_____
_____

3) The applicant is:

☐ Eligible Estimated Discount of $_____
☐ Ineligible

4) If Charity Care is denied, state the reason why the patient is ineligible.

_____
_____
_____

5) Signatures

_____ ____/____/____
Signature of person making eligibility determination Date

_____ ____/____/____
Supervisor, Patient Access Date

_____ ____/____/____
Director, Patient Access Date

Methodist Hospital of Chicago (A Division of Bethany Methodist Corporation)

5025 North Paulina | Chicago, Illinois 60640 | 773-271-9040
www.methodistchicago.org

- Has link for "Financial Assistance" from the home page
- Has link to Financial Assistance form .pdf
- Online financial assistance text:

If you require financial assistance in meeting your healthcare expenses for services rendered at Methodist Hospital of Chicago please contact the Patient Accounts office by telephone at 773-989-1306 or by mail addressed to Patient Accounts, Methodist Hospital of Chicago, 5025 North Paulina Street, Chicago, IL 60640-2772. In order to view or print the Financial Assistance form, please click here.

Methodist Hospital of Chicago

Charity Hospitalization Program

METHODIST HOSPITAL OF CHICAGO
FINANCIAL ASSISTANCE APPLICATION

Patient Name:_____ Admission(s) # _____

GUARANTOR INFORMATION

Name: _____ Relationship To Patient: _____

Address: _____ Employer: _____

City: _____ Employer's Phone: _____

State & Zip Code: _____ Spouse's Name: _____

Home Phone: _____ Spouse's Date of Birth: _____

Social Security #: _____ Social Security #: _____

Date of Birth: _____ Spouse's Employer: _____

Employer's Phone: _____

Please indicate the number of dependents you
Claimed on last year's IRS Income Tax Return:
_____

INCOME AND ASSETS

Guarantor's Monthly Gross Income: $_____

Spouse's Monthly Gross Income $_____

Other Monthly Income* $_____

Total Monthly Income: $_____ x 12 - $_____ = Total Annual Gross Income

Bank Name:** _____ Checking Account Balance: $_____

Savings Account Balance: $_____

Retirement/ 401K/ CD, etc. _____

Source of Other Income: _____

* Include child support, alimony, disability, welfare, food stamps, and unemployment compensation

** Provide copy of bank statement

List of all major assets and their value (Automobile(s), Property, etc; Do not list primary residence)

Item Value Estimated

_____ $_____

_____ $_____

_____ $_____

_____ $_____

PLEASE PROVIDE A COPY OF YOUR DRIVER'S LICENSE (OR STATE ID) AND SOCIAL SECURITY CARD. ALSO INCLUDE A COPY OF LAST YEAR'S W-2 FORMS, INCOME TAX STATEMENT OR LAST 2 PAY STUBS.

The information disclosed above is true and represents a total disclosure of all obligations. I authorize Methodist Hospital of Chicago to obtain credit reports, or other financial confirmation. I will promptly notify Methodist hospital of Chicago if my financial position significantly changes.

_____ _____

Patient Signature Date

_____ _____

Guarantor Signature (if applicable) Date

Mount Sinai Hospital

California Blvd. at 15th Street | Chicago, IL | 60608 | (888) AT-SINAI
www.sinai.org

- No link for financial assistance from home page; used search engine for "financial assistance"
- Has "Financial Assistance Application" link (pdf) in English and Spanish
- Online financial assistance text:

FINANCIAL ASSISTANCE

Financial Assistance Applicants:
Sinai's Mission is to improve the health of the individuals and communities we serve. We want to ensure that a systematic process exists for the provision of medical care at a reduced rate to those patients who have documented limited resources to pay.

Although reimbursement for services rendered is critical to the operation and stability of Sinai Health System, it is recognized that not all individuals possess the financial ability to purchase essential medical services. Therefore, in keeping with the System's commitment to serve all members of its community, a reduced fee agreement will be considered in situations where the need and inability to pay co-exist. The healthcare services provided will be reimbursed at a reduced level based on established income criteria as defined in the financial assistance policy. ***Financial Assistance Applications are available to any patients expressing a need for financial help.***

- *Click here for a copy of the Financial Assistance Application in English*
- *Click here for a copy of the Financial Assistance Application in Spanish*

Sinai Health Systems will require a nominal co-pay for individuals who qualify for Sinai Health System Financial Assistance Program. Upon completion of the financial assistance application an analysis will be completed to determine your financial responsibility. This co-pay varies depending on the service and is required each time you receive services. Please call our Financial Counseling office to receive further information regarding this policy (773) 257-1777.

SINAI
Sinai Health System California Avenue at 15th Street ▪ Chicago, IL 60608 ▪ (773) 542-2000 ▪ TDD (773) 542-0040

FINANCIAL ASSISTANCE AT SINAI HEALTH SYSTEM

The mission of Sinai Health System (Sinai) is to improve the health of the individuals and communities it serves. Sinai caregivers recommend appropriate medical care and treat all patients with respect and fairness regardless of an individual's ability to pay.

In keeping with its mission, Sinai has a financial assistance program to help patients pay for essential medical services. This program allows patients who are unable to access public programs, such as Medicare, Medicaid, Crime Victims Assistance, or any other program, be eligible for free or discounted health care services. Financial assistance is available for services at Mount Sinai Hospital, Schwab Rehabilitation Hospital, and Sinai Medical Group.

Financial Assistance Applications are available to any patient who expresses a need for financial help. To apply for financial assistance, please bring the attached application to a financial counselor at Mount Sinai Hospital or Schwab Rehabilitation hospital. Financial Counselors are available between 8:30 am and 5:00 pm.

It is Sinai's policy to verify your identity, income, family size, and residency. Along with your completed application, **please bring**:

- Photo Identification
- Proof of Income
  - IRS tax returns for the most recent calendar year;
  - All W-2 or 1099 forms for the most recent calendar year;
  - Last 3 current paystubs or any official documents from an employer if paid in cash;
  - One other reasonable form of income verification deemed acceptable by the hospital, such as pension, social security benefits or child support checks; and/or
  - A room and board letter;
- Proof of Dependents
  - Birth certificates of each dependent child, or other formal document.
- Proof of Illinois Residency *You only need to bring one (1) of the following forms of proof:*
  - Any of the documents requested as part of income verification;
  - Illinois Voter registration card;
  - A lease agreement;
  - A vehicle registration card;
  - Mail addressed to the uninsured patient at an Illinois address from a governmental or other credible source;
  - Sinai may utilize alternative sources, when available, to validate residency.
- If you needed healthcare because you were the victim of a crime, please bring a copy of the police report.

In certain cases, Sinai is able to offer patients a charity discount without an application. **Before submitting an application for financial assistance, please ask one of Sinai's financial counselors whether you qualify for a charity discount!** You may reach a financial counselor by calling (773) 257-1777, or by visiting your Sinai hospital. Thank you for choosing Sinai as your healthcare provider!

SINAI HEALTH SYSTEM
FINANCIAL ASSISTANCE APPLICATION
FINANCIAL STATEMENT

I hereby request that Sinai Health System make a written determination of my eligibility for financial assistance. I understand that Sinai will verify the information I provide concerning my residency, family size and income. I also understand that if the information is false, I will be liable for all charges for services that I receive.

1. Patient and Responsible Party Information

Patient Name: _____
First Middle Last

Responsible Party *(if different from patient):*

_____
First Middle Last

Patient's Address: _____
Number and Street

_____
City State Zip Code

Patient's Phone: _____ Cell: _____ Work: _____

Patient's Date of Birth: _____

Sinai Account Number(s), if known: _____

2. Employer Information

Occupation: _____

Employer: _____

Employer Address: _____
Number and Street

_____
City State Zip Code

3. Income Information (Please provide proof of reported income)

	Total for 1 Month	Total Annual Income
Wages		
Public Assistance		
Unemployment Compensation		
Workers Compensation		
Pension		
Child Support		
Income from Dividends		
Interest, Rent		
Other		
Total		

4. Family Size Information

Total Number of Dependents: *(Number of individuals for whom you are financially responsible.)*_____

Name	Relationship	Age

I affirm that the information that has been provided in this Financial Statement is true and correct to the best of my knowledge.

_____ _____

Signature of Patient/Responsible Party Date

SINAI
Sinai Health System California Avenue at 15th Street ▪ Chicago, IL 60608 ▪ (773) 542-2000 ▪ TDD (773) 542-0040

AYUDA FINANCIERA EN SINAI HEALTH SYSTEM

La misión de Sinai Health System (Sinai) es mejorar la salud de los individuos y comunidades a las que sirve. Cuidadores de Sinaí recomiendan atención médica apropiada y tratan a todos los pacientes con respeto y equidad independientemente de la capacidad de un individuo a pagar.

De acuerdo con su misión, Sinai tiene un programa de asistencia financiera para ayudar a los pacientes a pagar sus servicios médicos esenciales. Este programa permite a los pacientes que no pueden acceder a programas públicos, tales como Medicare, Medicaid, Asistencia por Víctimas de Delitos o cualquier otro programa. El paciente puede ser eligible para recibir ayuda médica gratuita o recibir descuentos per sus gastos médicos. La ayuda financiera está disponible para los servicios en Mount Sinai Hospital, Schwab Rehabilitation Hospital, y Sinai Medical Group.

Las Aplicaciones de asistencia financiera están disponibles para cualquier paciente que exprese la necesidad de recibir ayuda financiera. Para solicitar asistencia financiera, por favor traiga la solicitud adjunta a un asesor financiero en Mount Sinai Hospital o Schwab Rehabilitation Hospital. Los consejeros financieros están disponibles entre las 8:30 a.m. y 5:00 pm.

Es política de Sinai verificar su identidad personal, ingresos económicos, tamaño de la familia, y la dirección de residencia. Junto con su aplicación completada, **por favor traiga**:

- Foto de Identificación
- Prueba de Ingresos
  - Devoluciones de impuestos del IRS para el año más reciente;
  - Todas las formas W-2 o 1099 para el año más reciente;
  - Copias de 3 últimos cheques de pago. Si a usted le pagan en efectivo traiga una carta de la compañia de su empleador indicando su ingreso semanal y su tiempo en el empleo;
  - Copias de cualquiere otro tipo de ingreso, tales como las pensiones, prestaciones de la seguridad social o mantienimiento de niños.
- Prueba de Dependientes
  - Certificados de nacimiento de cada hijo dependiente, o otro documento formal.
- Prueba de residencia de Illinois *Sólo necesita traer una (1) de las siguientes formas de prueba:*
  - Cualquiera de los documentos solicitados como parte de la verificación de ingresos;
  - Tarjeta de registro de votantes de Illinois;
  - Un contrato de arrendamiento;
  - Una tarjeta de registro del vehículo;
  - Correo dirigido al paciente donde muestre la dirección de su residencia (recibo de aluz, gas, cable, telefono) o otra fuente creíble;
  - Sinaí puede utilizar fuentes alternativas, cuando esté disponible, para validar la residencia.
- Si usted necesitara la asistencia médica porque usted era la víctima de un delito, por favor traiga una copia del informe de policía.

En algunos casos, Sinai es capaz de ofrecer a los pacientes una caridad descuento sin una aplicación. **¡Antes de presentar una solicitud de la asistencia financiera, por favor pregunte a uno de los consejeros financieros de Sinai si usted tiene derecho a un descuento de caridad!** Usted puede comunicarse con un consejero financiero llamando al (773) 257-1777, o visitando su hospital de Sinai. ¡Gracias por elegir a Sinai!

SINAI HEALTH SYSTEM
SOLICITUD DE ASISTENCIA FINANCIERA
ESTADO FINANCIERO

Solicito que Sinai Health System haga por escrito mi determinación relacionada a la elegibilidad para recibir asistencia financiera. Yo entiendo que Sinai verificará la información que proporcione relacionada a mi residencia, tamaño de la familia y los ingresos económicos. También entiendo que si la información es falsa, seré responsable de todos los cargos relacionados a los servicios médicos que recibo.

1. Información del Paciente y los Partes Responsables

Nombre del Paciente: _____
Primer Nombre Segundo Nombre Apellido

Partes Responsables (Si es diferente al paciente)*:*

_____ _____ _____
Primer Nombre Segundo Nombre Apellido

Dirección del Paciente: _____
Numero y Calle

_____
Ciudad Estado Código postal

Teléfono del Paciente: _____ Celular: _____ Trabajo: _____

Fecha de Nacimiento del Paciente: _____

Número de cuenta, si se conoce: _____

2. Información del Empleador

Ocupación: _____

Empleador: _____

Dirección del Empleador: _____
Numero y Calle

_____
Ciudad Estado Código postal

3. Información de Ingresos (Por favor incluya sustantivo prueba de ingresos)

	Total de 1 Mes	Ingreso Anual Total
Salario		
Asistencia Pública		
Subsidio de Desocupación		
Compensación de Trabajadores		
Ingresos de Pensión		
Ingresos de Ayuda de Niño		
Ingresos de Dividendos		
Ingresos de Alquiler		
Otra		
Total		

4. Información de Tamaño de Familia

Número Total de Dependientes: *(Número de personas para quienes usted es financieramente responsable)*_____

Nombre	Relación	Edad

Afirmo que la información que he proporcionado en este estado financiero es verdadera y correcta a lo mejor de mi conocimiento.

_____ _____

Firma del Paciente or Parte Responsable Fecha

Northwestern Memorial Hospital

251 East Huron ⏐Chicago, Illinois 60611-2908 ⏐ (312) 926-2000
www.nmh.org

- Has link to financial assistance via "Pay Your Bills" from the home page
- Has Brochure on assistance programs online in English and Spanish.
- Has an application for financial assistance programs online in English, Spanish, Polish and Russian
- Has information re: Medicare Policies, Commercial Insurance Policies and Blue Cross Policies online
- Online financial assistance text:

Northwestern Memorial is a nonprofit hospital that offers a range of financial assistance programs to ensure that quality healthcare is accessible to everyone including those who are least able to afford it. Both uninsured patients and those with medical insurance but who may be left with balances they cannot afford to pay may qualify for the following financial assistance programs:

*Our **Free Care Program** offers free care based on family size and income of up to 250 percent of the federal poverty guidelines and other criteria.*

*Our **Discounted Care Program** offers discounted care based on family size and income up to 600 percent of the federal poverty guidelines and other criteria.*

*Our **Catastrophic Discount Program** provides relief for patients by limiting the total out-of-pocket costs for patients who may not qualify for other financial assistance programs, but for whom medical debt could create a significant financial burden.*

*Our **Uninsured-Noncovered Services Discount Program** offers discounts on hospital bills for uninsured patients who do not qualify for free or discounted care. This program also offers discounts to insured patients who have claims for medically necessary services that are not covered by their insurance plans.*

*Our **Extended Payment Plan Program** offers payment arrangements for patients*

24-Hour Account Access
www.nmh.org
1.800.845.9028

Billing Representatives
8 a.m. to 5 p.m., Monday through Friday
312.926.6900 or 1.800.845.9028

Financial Counselors
8 a.m. to 5 p.m., Monday through Friday
1.800.423.0523

Important Email: *billing@nmh.org*

Walk-in customer service
Northwestern Memorial Hospital
Business Office & Cashier
251 East Huron
Feinberg Pavilion – 2nd Floor

Walk-in hours
8:30 AM - 5:00 PM Monday through Friday

Phone numbers
Feinberg Business Office – (312) 926-6906
Billing Inquiry Unit - (312)-926-6900

Northwestern Memorial Hospital

skip to the content

Need Assistance?

Email Us *or contact our Hospital Operators* 312-926-2000

- Return to nmh.org

Online Patient Billing

Northwestern Memorial Hospital is a nonprofit hospital that offers a range of financial assistance programs to ensure that quality healthcare is accessible for everyone including those who are least able to afford it. Both uninsured patients and those with medical insurance but who may be left with balances they cannot afford to pay may qualify for the following financial assistance programs:

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Our **Extended Payment Plan Program** offers payment arrangements for patients who may be unable to pay the balance at one time.

To learn more About Your Hospital Bill...Click here to review our brochures.

Brochure (English) Brochure (Spanish)

Please note that eligibility criteria, terms and conditions vary for each of the financial assistance programs listed above. Our financial counselors can help you further understand if you qualify for any of these programs and can assist you with the application process.

Checklist & Application (English) Checklist & Application (Spanish) Checklist & Application (Polish) Checklist & Application (Russian)

If you have any questions regarding any of our financial assistance programs please contact Financial Counseling at 312-926-6906 or 800-423-0523.

- Home
- My Account
- Resources
- Billing Policies
  - Payment Options
  - Self Pay
  - Medicare Policies
  - Blue Cross Policies
  - Commercial Insurance Policies
- Billing Help
- Contact Us
- Logout

top

Northwestern Memorial Hospital, 251 E. Huron Street, Chicago, IL, 60611

Northwestern Memorial® Hospital

About Your Hospital Bill

Helpful information about the billing process, medical insurance claims and financial assistance programs, including free and discounted care.

Thank you for choosing Northwestern Memorial Hospital for your healthcare services.

Our longstanding commitment to quality and service can be seen through the work we do each day to provide our patients with the best possible experience in a healing environment.

We know that hospital bills, healthcare claims and the payment process can be complicated and difficult to understand. As a way of helping you through this process, we have developed this brochure to answer some of the most frequently asked questions about billing and payment options, including important information that can help you understand what financial assistance might be available if you believe that you may be unable to pay your bill.

Also in this brochure, you will find suggestions about steps you can take to save time and help us better assist you during this process. This includes information about our financial counselors who can provide individualized assistance to help you determine your payment options. If you are uninsured or if your medical insurance will leave you with a balance you may have difficulty paying, our financial counselors can work with you to determine if you qualify for one of our financial assistance programs including free or discounted care.

At Northwestern Memorial, we are dedicated to providing quality medical care to those in need of our services, regardless of the ability to pay. Your financial circumstances will not impact the care you receive as you will be treated with compassion, dignity and respect.

Every patient treated at Northwestern Memorial Hospital receives a bill that summarizes the hospital services provided and details the balance due. *Please keep in mind that physicians and surgeons bill you separately for their services as do other medical specialists who may be involved in your care such as radiologists, anesthesiologists and pathologists.* For patients with medical insurance, your costs are based on the terms of your policy and the benefits of your plan. It is important for you to know that your insurance plan may not cover your total medical expense, which means that some amount of your bill becomes your personal responsibility. You can expect the following from Northwestern Memorial:

We will bill your medical insurance carriers on your behalf.

With your authorization, we will bill your medical insurance plan, including Medicare and Medicaid. If you have more than one plan, we will bill your additional insurance companies. We will bill your insurer for the full amount of your charges, but please be aware that your insurer may have a contract with the hospital that requires us to accept a discounted amount.

You will receive timely statements.

Your statement will include the most current balance due from your medical insurance plan or from you. We will send you a statement after your insurance has paid to notify you of any remaining balance. If you need personal assistance, our billing representatives can be reached from 8 a.m. to 5 p.m., Monday through Friday, at **312-926-6900** or **1-800-845-9028**.

You can access your account information anytime, day or night.

Northwestern Memorial's Web site provides you with convenient, around-the-clock access to your account. You can go online to update your personal information, make a payment or obtain additional information related to your bill. To access your account, please go to **www.nmh.org** and click on either the "Financial Assistance" or "View Account/Make a Payment" links, both of which are located on the lower right-hand corner of the home page. You also can access your account information by using our automated telephone system any time of day by calling **312-926-6900** or **1-800-845-9028**.

You will have access to a financial counselor.

Our financial counselors can answer questions you and your family may have about hospital charges, medical insurance benefits and payment options. In addition, these counselors can help you determine if you might qualify for one of our

financial assistance programs and assist you with completing the paperwork. Translation services are available so that you may speak to a financial counselor in your own language. Our financial counselors can be reached at **1-800-423-0523**.

It is important that you take an active role in understanding your hospital bill, processing medical insurance claims and in working with us to determine if you are eligible for financial assistance. Even if you do not qualify, we will work with you to establish a payment plan. There are a number of steps that you can take to help:

Provide us with complete medical insurance information at the time of your hospital registration.

Please make sure that we have all of your medical insurance information and authorization forms. We will ask you to sign a form that will authorize us to release information to your insurance company and assign payment to the hospital.

Understand and comply with the requirements of your insurance plan.

You may be able to reduce delays and potentially some out-of-pocket costs if you are familiar with your medical insurance coverage and follow required procedures. Please review the handbook provided by your medical insurance company or call the customer service number on the back of your insurance card if you have questions about your coverage. To reduce payment delays, make sure to complete and return the "coordination of benefits" form if this is requested.

Respond promptly to requests you receive from your insurer.

While we will attempt to provide all of the necessary information and paperwork to process your claims, sometimes a response from you will be required to resolve issues related to your account or your medical insurance coverage, especially if you have more than one insurance plan. If your insurance company has not issued a payment within a reasonable amount of time and has not responded to our attempts to resolve payment matters on your behalf, please understand that the balance owed may become your responsibility.

Contact us if you have questions or concerns about your hospital bill.

Our billing representatives can address your questions and either provide an explanation or direct you to the right place for an answer. Our billing representatives are available from 8 a.m. to 5 p.m., Monday through Friday, at **312-926-6900** or **1-800-845-9028**.

If you anticipate problems paying for your portion of the bill, let us know.

Our financial counselors can help you understand the many financial options that may be of assistance such as free care, discounted care or extended payment plans. To apply, you will be required to provide us with certain personal and financial information so that we can help determine if you qualify.

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Our **Uninsured-Noncovered Services Discount Program** offers discounts on hospital bills for uninsured patients who do not qualify for free or discounted care. This program also offers discounts to insured patients who have claims for medically necessary services that are not covered by their insurance plans.

Our **Extended Payment Plan Program** offers payment arrangements for patients who may be unable to pay the balance at one time.

Please note that eligibility criteria, terms and conditions vary for each of the financial assistance programs listed above. Our financial counselors can help you further understand if you qualify for any of these programs and can assist you with the application process.

Northwestern Memorial® Hospital

251 East Huron
Chicago, Illinois 60611-2908
312.926.2000
www.nmh.org

24-Hour Account Access

www.nmh.org
1.800.845.9028

Billing Representatives

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Financial Counselors

8 a.m. to 5 p.m., Monday through Friday
1.800.423.0523

OUR MISSION

Northwestern Memorial Hospital is an academic medical center where the patient comes first. We are an organization of caregivers who aspire to consistently high standards of quality, cost effectiveness and patient satisfaction. We seek to improve the health of the communities we serve by delivering a broad range of services with sensitivity to the individual needs of our patients and their families. We are bonded in an essential academic and service relationship with the Feinberg School of Medicine of Northwestern University. The quality of our services is enhanced through their integration with education and research in an environment that encourages excellence of practice, critical inquiry and learning.

Para asistencia en español, por favor llamar al Departamento de Representantes para Pacientes al 312-926-3112.

Northwestern Memorial is an equal opportunity employer that welcomes, respects and serves with dignity all people and does not discriminate, including in hiring, or employment, or admission, or access to, or treatment in its programs or activities on the basis of race, color, gender, national origin, religion, disability, handicap, age, Vietnam or other veteran status, sexual orientation or any other status protected by relevant law. To arrange for TDD/TTY, auxiliary aids and foreign language interpretation services, or for issues related to the Rehabilitation Act of 1973, call the Patient Representative department at 312-926-3112, TDD/TTY number 312-926-6363.

Division of Public Relations, Marketing and Physician Services
For more information about Northwestern Memorial Hospital, please visit www.nmh.org.
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Gracias por elegir el Northwestern Memorial Hospital para que le brinde sus servicios de atención médica.

Nuestro compromiso con la calidad y el servicio se refleja en el trabajo que hacemos cada día, para brindar a nuestros pacientes la mejor experiencia posible en un ambiente que promueva su curación.

Sabemos que las facturas del hospital, los pedidos de reembolso y el proceso de pago pueden ser complicados y difíciles de entender.

Para ayudarlo a lo largo de este proceso, hemos confeccionado un folleto que responde a algunas de las preguntas más frecuentes; relacionadas con las opciones de facturación y pago. También incluye información relevante que puede ayudarle a comprender la asistencia financiera que, en caso que no pueda pagar su factura, puede ponerse a su disposición.

Además, en este folleto encontrará sugerencias respecto a los pasos a seguir para ahorrar tiempo y ayudar en este proceso. Ésto incluye información sobre nuestros consejeros financieros; quienes pueden brindarle asistencia personalizada para ayudarle a determinar sus opciones de pago. Si no tiene seguro o si su seguro médico le deja un saldo cuyo monto no pueda pagar, nuestros consejeros financieros trabajarán con usted para determinar si reúne los requisitos para alguno de nuestros programas de asistencia financiera, esto incluye cuidado gratuito o con descuento.

En el Northwestern Memorial nos dedicamos a proveer un cuidado médico de calidad a aquellos que necesitan nuestros servicios, sin importar la capacidad de pago. Sus circunstancias financieras no afectarán el cuidado que reciba, dado que será tratado con contención, dignidad y respeto.

Northwestern Memorial Hospital

251 East Huron Street
Chicago, Illinois 60611-2908
312.926.2000
www.nmh.org

Acceso a la cuenta las 24 horas
www.nmh.org
1.800.845.9028

Representantes de facturación
De lunes a viernes, de 8 a.m. a 5 p.m.
312.926.6900 or 1.800.845.9028

Consejeros financieros
De lunes a viernes, de 8 a.m. a 5 p.m.
1.800.423.0523

Para asistencia en español, por favor llamar al departamento de representantes para pacientes al 312-926-3112.

Nuestra Misión

El Northwestern Memorial es un centro médico universitario en donde se prioriza el paciente. Somos una organización de proveedores de cuidado de la salud que aspira a estándares altos y coherentes de calidad, rentabilidad y satisfacción del paciente. Buscamos mejorar la salud de las comunidades a las cuales servimos, a través de una amplia variedad de servicios con sensibilidad para las necesidades individuales de nuestros pacientes y de sus familias. Tenemos una relación con la escuela de Medicina Feinberg de la Universidad de Northwestern que es esencialmente académica y de servicio. La calidad de nuestros servicios se ve mejorada mediante la integración de educación e investigación, en un entorno que fomenta la excelencia, las preguntas cruciales y el aprendizaje.

Northwestern Memorial Hospital

Su Factura del Hospital

Información útil sobre el proceso de facturación, reclamos de seguro médico y programas de asistencia financiera, incluyendo cuidado gratuito y con descuentos.

Todos los pacientes que son tratados en el Northwestern Memorial Hospital, reciben una factura que resume los servicios prestados por el hospital y detalla el saldo adeudado. *Recuerde que los médicos y cirujanos le cobrarán por sus servicios prestados de forma separada; al igual que otros especialistas que pudiesen participar de su cuidado, como por ejemplo, radiólogos, anestesistas y patólogos.* En el caso de los pacientes que tienen seguro médico, sus gastos dependen de los términos y condiciones de su póliza y de los beneficios de su plan. Es importante que sepa que su plan de seguro puede no cubrir la totalidad de sus gastos médicos. Lo que significa que parte del monto de su factura será su responsabilidad personal. Puede esperar del Northwestern Memorial lo siguiente:

Le cobraremos en su nombre a la compañía de seguro médico.

Con su autorización le cobraremos a su plan de seguro médico; incluyendo a Medicare y Medicaid. Si tiene más de un plan, también les cobraremos a las aseguradoras adicionales. Le cobraremos a su compañía de seguros el monto total de sus gastos, pero debe saber que su compañía puede tener un contrato con el hospital que nos obligue a aceptar un monto menor.

Recibirá las facturas en un tiempo razonable.

Su factura incluirá el saldo más actualizado que usted o su plan de seguro médico deba pagar. Le enviaremos un comunicado, luego de que su seguro haya pagado, para notificarle si existe algún saldo remanente. Si necesita asistencia personal, puede comunicarse con nuestros representantes de facturación, de lunes a viernes, de 8 a.m. a 5 p.m., llamando al 312-926-6900 o 1-800-845-9028.

Puede acceder a la información de su cuenta en cualquier momento; de día o de noche.

El sitio Web del Northwestern Memorial le provee acceso a su cuenta las 24 horas al día. Puede conectarse a Internet para actualizar su información personal, efectuar pagos u obtener información adicional respecto de su cuenta. Para acceder a su cuenta, ingrese a www.nmh.org y haga clic en los enlaces “Financial Assistanse” (Asistencia Financiera) o “View Account” (Panorama de la Cuenta) o “Make a payment” (Realice un pago), los mismos se encuentran ubicados en la parte inferior derecho de la página principal. También puede acceder a la información de su cuenta, a través de nuestro sistema de teléfono automatizado, en cualquier momento del día, llamando al 312-926-6900 o 1-800-845-9028.

Tendrá acceso a consejeros financieros.

Nuestros consejeros financieros pueden responder a las preguntas que usted o su familia pueda tener respecto a los gastos hospitalarios, beneficios del seguro médico y las opciones de pago. Además, estos consejeros pueden determinar si usted reúne los requisitos para uno de nuestros programas de asistencia y ayudarle a completar los formularios. Se encuentran disponibles los servicios de traducción, para que pueda hablar con éstos en su propio idioma. Puede comunicarse con nuestros consejeros financieros llamando al 1-800-423-0523.

Es importante que asuma un rol activo en tareas como entender su factura del hospital, realizar reclamos a su seguro médico y trabajar junto a nosotros para poder determinar si reúne los requisitos para recibir asistencia financiera. Si usted no califica, también podemos trabajar con usted para establecer un plan de pago. Existen un número de pasos que puede seguir:

Proporcionando la información completa de su seguro médico en el momento en que se registra en el hospital.

Asegúrese de que tengamos toda la información de su seguro médico y todos los formularios de autorización. Le haremos firmar un formulario a través del cual usted nos autorizará a mostrarle información a su compañía de seguro y atribuirle el pago al hospital.

Entender y cumplir con los requisitos de su plan de seguro.

Si conoce la cobertura de su seguro médico y sigue los procedimientos requeridos, quizás pueda disminuir las demoras y posibles gastos de bolsillo. Revise el manual que le dio su compañía de seguro médico o llame al número de atención al cliente que se encuentra en la parte trasera de su tarjeta de seguro, en caso de que tener dudas respecto a su cobertura. Para disminuir las demoras en el pago, asegúrese de completar y devolver el formulario “coordination of benefits” (coordinación de beneficios)

Responder rápidamente a los pedidos de su compañía de seguros.

Mientras intentamos proveer toda la información y los formularios necesarios para tramitar sus reembolsos, a veces le pediremos que colabore para que podamos resolver temas relacionados con su cuenta o cobertura médica; principalmente si usted tiene más de un plan de seguro. Si su compañía de seguro no pagó en un tiempo razonable y no respondió a nuestros intentos por resolver el pago a su nombre, le pedimos que entienda que el saldo adeudado puede transferirse a usted.

Comunicarse con nosotros si tiene preguntas o inquietudes con respecto a su factura del hospital.

Nuestros representantes de facturación pueden responder sus inquietudes y proveerle una explicación; o bien dirigirlo al lugar apropiado en donde responderán a sus preguntas. Nuestros representantes de facturación se encuentran disponibles de lunes a viernes, de 8 a.m. a 5 p.m., en el teléfono 312-926-6900 o 1-800-845-9028.

Si prevé problemas con el pago de la parte de la deuda que le corresponde a usted, háganoslo saber.

Nuestros consejeros financieros pueden asistirle para que entienda todas las opciones financieras que le puedan servir de ayuda; como por ejemplo, cuidado gratuito, cuidado con descuento o planes de pago sin interés. Para solicitar uno de estos programas, tendrá que otorgarnos información personal y financiera específica, para determinar si reúne los requisitos.

El Northwestern Memorial es un hospital sin fines de lucro, que ofrece una variedad de programas de asistencia financiera para asegurar que la atención médica de calidad sea accesible para todos; incluyendo a los que menos la pueden pagar. Tanto los pacientes no-asegurados, como aquellos que tienen seguro médico pero deben hacerse cargo de un monto que no pueden pagar, pueden calificar para los siguientes programas de asistencia financiera:

Nuestro **Programa de Cuidado Gratuito** ofrece atención médica basada en el tamaño de la familia y en el nivel ingresos, de hasta 250 por ciento de los parámetros de pobreza establecidos por el gobierno federal, u otros criterios.

Nuestro **Programa de Cuidado con Descuentos** ofrece cuidado con descuento según el tamaño de la familia y el nivel de ingresos de hasta 400 por ciento de los parámetros de pobreza establecidos por el gobierno federal, u otros criterios.

Nuestro **Programa de Necesidad Catastrófica** provee ayuda a aquellos que no pueden calificar para asistencia federal, pero que pueden tener problemas financieros importantes debido a su deuda médica.

Nuestro **Programa de Plan de Pago sin Interés** ofrece formas de pago a largo plazo para pacientes que no puedan pagar el saldo en una sola oportunidad.

Nuestro **Programa de Descuento** ofrece descuentos en las facturas del hospital a los pacientes que reúnen los requisitos y que no califican para uno de nuestros programas de asistencia financiera.

Note que el criterio, los términos y los requisitos varían para cada uno de los programa de asistencia financiera mencionados. Nuestros consejeros financieros pueden ayudarle a entender mejor si reúne los requisitos para cualquiera de estos programas y también ayudarle en el proceso de su solicitud.

Northwestern Memorial Hospital

Заявка на участие в программе финансовой помощи

Мы понимаем, что расходы на медицинское обслуживание часто бывают незапланированными, и при возникновении финансовых трудностей мы помогаем своим пациентам найти доступные ресурсы для оплаты медицинских счетов. Больница Northwestern Memorial Hospital гарантирует всем пациентам высококачественное медицинское обслуживание независимо от индивидуальных возможностей его оплаты.

Northwestern Memorial Hospital предлагает разнообразные программы финансовой помощи для удовлетворения потребностей наших застрахованных и незастрахованных пациентов. Программы финансовой помощи предполагают бесплатное лечение, скидки на лечение и планы продленных сроков оплаты. При наличии соответствующего разрешения данная программа может покрывать необходимые по медицинским показаниям услуги, предоставляемые больницей Northwestern Memorial Hospital и нашим пунктом оказания неотложной помощи. Она не распространяется на какие-либо прочие платы, которые могут потребоваться от пациента. Чтобы помочь нам установить ваше право на получение финансовой помощи, **заполните, подпишите и верните** нам данную заявку вместе с копиями каких-либо из имеющихся у вас перечисленных ниже подтверждающих документов, включая:

- ☐ Водительское удостоверение или иное выданное штатом удостоверение личности
- ☐ Последнюю декларацию о федеральном подоходном налоге, графики оплаты и формы W2

Если вы не заполняли налоговую декларацию, предоставьте нам какой-либо из перечисленных документов:

- ☐ Корешки от зарплатных чеков за три последних месяца или иной документ, подтверждающий доход
- ☐ Письмо с решением о выплате вам социального пособия (по размеру дохода или инвалидности)
- ☐ Письмо(а) с решением о выплате вам материальной помощи на какие-либо студенческие ссуды или гранты
- ☐ Письмо с решением о выплате льготного пособия по безработице

Отправьте заявку и все подтверждающие документы по адресу:

Northwestern Memorial Hospital
Patient Financial Services
251 East Huron St., #2-304
Chicago, IL 60611

После получения вашей заявки по ней будет принято вешение, и вам будет направлен ответ в письменной форме в течение тридцати (30) дней с даты получения от вас пакета документов с заполненной заявкой. Если у вас возникли дополнительные вопросы, или вам требуется помощь в заполнении заявки, позвоните нам по телефону 312-926-6906 или по бесплатному номеру 800-423-0523.

Northwestern Memorial Hospital

Заявка на участие в программе финансовой помощи

Имя пациента:_____ _____ **Дата рождения:** _____ **Кол-во членов семьи:**____

Годовой доход заявителя:_____ **Годовой доход супруга(и) или неприменимо:** ___

ИНФОРМАЦИЯ О ПАЦИЕНТЕ ИЛИ ПОРУЧИТЕЛЕ

Имя, фамилия: _____ **Кем приходится пациенту:** _____

Постоянный адрес: _____ **Номер домашнего телефона:** ( ) _____

_____ **Номер мобильного телефона:** ( ) _____

Работаете ли вы в настоящее время? Да ☐ Нет ☐ ☐ Штатный сотрудник ☐ Неполная занятость

Имя работодателя::_____ **Род деятельности:**_____

Постоянный адрес: _____ **Телефон:** ( ) _____

_____

Если вы являетесь безработным в настоящее время, была ли у вас (или вашего(ей) супруга(и)) работа в течение последних 6 месяцев? Да ☐ Нет ☐

Адрес электронной почты: _____

Пользовались ли вы услугами пункта оказания неотложной помощи? Да ☐ Нет ☐

Являетесь ли вы бездомным? Да ☐ Нет ☐

ИМУЩЕСТВО

1. **Ваше основное место проживания находится в вашей собственности ☐, вы его снимаете ☐?**
   Каков размер вашей месячной оплаты? _____

   Если имущество находится в собственности, какова его примерная рыночная стоимость на данный момент: _____

2. **Владеете ли вы другой недвижимостью?** Да ☐ Нет ☐

   Если да, какова его рыночная стоимость на данный момент: _____

3. **Есть ли у вас автомобиль?** Да ☐ Нет ☐

   Если да, какова его рыночная стоимость на данный момент: _____

4. **Есть ли у вас какие-либо банковские или брокерские счета?** Да ☐ Нет ☐

   Если да, укажите название(я) банка / брокерской компании: _____
   Общее сальдо по счету: _____

5. **Владеете ли вы чем-либо из перечисленного? (отметьте все, что применимо)**

   ☐ Акции / облигации текущая стоимость:_____

   ☐ Депозитное свидетельство текущая стоимость: _____

   ☐ Другое имущество текущая стоимость:_____

Northwestern Memorial Hospital

Заявка на участие в программе финансовой помощи

ДРУГОЕ СТРАХОВАНИЕ

1. **Есть ли у вас какой-либо медицинский страховой полис, включая иностранную страховку, Medicaid или Medicare?**

   Да ☐ Нет ☐

   Если да, укажите следующую информацию:

   Держатель страхового полиса: _____

   Страховщик: _____

   Номер страхового полиса: _____

   Держатель страхового полиса: _____

   Страховщик: _____

   Номер страхового полиса: _____

2. **Являетесь ли вы студентом колледжа?** Да ☐ Нет ☐

   Если да: ☐ Очное обучение ☐ Заочное обучение Название школы: _____

   Есть ли у вас медицинская страховка в рамках студенческой страховой программы? Да ☐ Нет ☐

   Если да, укажите:

   Держатель страхового полиса: _____

   Страховщик: _____

   Номер страхового полиса: _____

   Приложите также последнюю декларацию о федеральном подоходном налоге, графики оплаты и формы W2 ваших родителей

3. **Есть ли у вас действующее разрешение на бесплатное или предполагающее скидку медицинское обслуживание в другой больнице или медицинском центре общины?**

   Да ☐ Нет ☐ Если да, где? _____

РАЗРЕШЕНИЕ И СОГЛАСИЕ

Настоящим даю свое согласие на разглашение информации, содержащейся в данной заявке, организации Northwestern Memorial Healthcare (NMHC) и/или фонду Northwestern Medical Faculty Foundation (NMFF) для установления моего права на участие в различных программах финансовой помощи в соответствии с политикой и процедурами, принятыми в каждой из организаций. Я разрешаю NMHC и NMFF провести необходимую проверку данной информации, которая может включать, но не ограничиваться этим, получение отчета от кредитного бюро, проверку данных о трудоустройстве и/или доходе и соответствующих подтверждающих документов.

Вся представленная мною в данной заявке информация и документы о доходах являются правдивыми, точными и полными, как указано. Если в любое время будет установлено, что какие-либо из представленных мною сведений являются ложными и/или неточными, все гранты на бесплатную медицинскую помощь должны быть возвращены, и я должен(должна) взять на себя полную ответственность за немедленную оплату всех и любых непогашенных остатков в полном объеме.

Я также соглашаюсь взять на себя ответственность за оплату любой причитающейся суммы после выдачи мне какого-либо гранта на частично бесплатное медицинское обслуживание.

Подпись пациента / поручителя: _____ Дата: _____

Northwestern Memorial Hospital

Wniosek o objęcie programem pomocy finansowej

Zdajemy sobie sprawę, że konieczność opłacenia usług medycznych to często nieplanowany wydatek. W przypadku trudności finansowych naszych pacjentów pomagamy w uzyskaniu dostępu do źródeł finansowania, pozwalających na uregulowanie płatności za usługi medyczne. Szpital Northwestern Memorial zapewnia objęcie wszystkich pacjentów opieką medyczną na wysokim poziomie bez względu na ich możliwości finansowe.

Szpital Northwestern Memorial oferuje szereg programów pomocy finansowej, wychodzących naprzeciw pacjentom ubezpieczonym i nieubezpieczonym. Programy pomocy finansowej obejmują bezpłatną opiekę medyczną, zniżki oraz plany spłat należności w ratach. Po wydaniu decyzji pozytywnej taki program obejmuje usługi niezbędne z medycznego punktu widzenia, świadczone przez szpital Northwestern Memorial oraz jego oddział ratunkowy. Nie dotyczy on żadnych innych opłat, ponoszonych przez pacjenta. Aby pomóc w ustaleniu, czy Pan/Pani może uzyskać pomoc finansową, prosimy o **wypełnienie, podpisanie i przekazanie nam** niniejszego wniosku wraz z kopiami dodatkowych dokumentów, w tym:

☐ prawa jazdy lub innego stanowego dokumentu potwierdzającego tożsamość

☐ federalnego zeznania podatkowego za ostatni rok, załączników i formularzy W2

W przypadku, gdy Pan/Pani nie składał(-a) zeznania podatkowego, prosimy o dostarczenie:

☐ trzech ostatnich odcinków wypłaty lub innego dowodu potwierdzającego wysokość dochodów

☐ zawiadomienia o objęciu ubezpieczeniem społecznym i przyznaniu numeru ubezpieczenia społecznego (z tytułu uzyskiwanych dochodów lub niepełnosprawności)

☐ zawiadomienia/zawiadomień o przyznaniu pożyczki lub kredytu studenckiego bądź stypendium

☐ pisma potwierdzającego przyznanie zasiłku dla bezrobotnych

Prosimy o przesłanie wniosku wraz z załączonymi dokumentami na adres:

Northwestern Memorial Hospital
Patient Financial Services
251 East Huron St., #2-304
Chicago, IL 60611

Po otrzymaniu wniosku nastąpi jego rozpatrzenie. Odpowiedź pisemną prześlemy w ciągu trzydziestu (30) dni, licząc od daty otrzymania przez nas kompletnego zestawu dokumentów. W przypadku pytań lub konieczności uzyskania pomocy przy wypełnianiu formularza prosimy o skontaktowanie się z nami pod numerem 312-926-6906 lub 800-423-0523 (bezpłatnie).

Northwestern Memorial Hospital

Wniosek o objęcie programem pomocy finansowej

Imię i nazwisko pacjenta: _____ **Data urodzenia:** _____ **Liczba członków rodziny:**_____

Roczny dochód wnioskodawcy: _____ **Roczny dochód współmałżonka lub Nie dotyczy:** __

DANE PORĘCZYCIELA LUB PACJENTA

Imię i nazwisko: _____ **Stopień pokrewieństwa z pacjentem:** _____

Stały adres zamieszkania: _____ **Nr domowego telefonu stacjonarnego:** ( )_____

_____ **Nr telefonu komórkowego:** ( )_____

Czy obecnie Pan/Pani pracuje? Tak ☐ Nie ☐ ☐ W pełnym wymiarze ☐ W niepełnym wymiarze

Nazwa pracodawcy: _____ **Wykonywany zawód:**_____

Stały adres zamieszkania: _____ **Nr telefonu:** ( ) _____

_____

Jeżeli nie jest Pan/Pani zatrudniony(-a), prosimy podać, czy Pan/Pani (lub współmałżonek) był(-a) zatrudniony w ciągu ostatnich 6 miesięcy? Tak ☐ Nie ☐

Adres e-mail: _____

Czy korzystał(-a) Pan/Pani ze świadczeń medycznych na oddziale ratunkowym? Tak ☐ Nie ☐

Czy jest Pan/Pani osobą bezdomną? Tak ☐ Nie ☐

AKTYWA

1. **Czy Pan/Pani posiada ☐ wynajmuje ☐ swoje podstawowe miejsce zamieszkania? Ile wynoszą miesięczne opłaty?** _____

   Jeżeli jest Pan/Pani właścicielem swojego miejsca zamieszkania, prosimy o podanie, ile wynosi w przybliżeniu jego obecna wartość rynkowa?_____

2. **Czy posiada Pan/Pani inne nieruchomości?** Tak ☐ Nie ☐_____
   Jeżeli tak, prosimy podać ich aktualną wartość rynkową:_____

3. **Czy posiada Pan/Pani samochód?** Tak ☐ Nie ☐ _____
   Jeżeli tak, prosimy podać jego aktualną wartość rynkową:_____

4. **Czy posiada Pan/Pani konta bankowe lub rachunki maklerskie?** Tak ☐ Nie ☐

   Jeżeli tak, prosimy podać nazwę banku/biura maklerskiego:_____

   Łączne saldo: _____

5. **Czy posiada Pan/Pani niżej wymienione? (prosimy zaznaczyć wszystkie stosowne odpowiedzi)**

   ☐ Papiery wartościowe aktualna wartość: _____

   ☐ Certyfikaty depozytowe aktualna wartość: _____

   ☐ Inne aktywa aktualna wartość: _____

Northwestern Memorial Hospital

Wniosek o objęcie programem pomocy finansowej

INNE UBEZPIECZENIE

1. **Czy jest Pan/Pani objęty(-a) innym ubezpieczeniem zdrowotnym, w tym zagranicznym, Medicaid i Medicare?**

   Tak ☐ Nie ☐

   Jeżeli tak, prosimy o podanie następujących informacji:

   Posiadacz polisy: _____

   Ubezpieczyciel:_____

   Numer polisy: _____

   Posiadacz polisy: _____

   Ubezpieczyciel:_____

   Numer polisy: _____

2. **Czy jest Pan/Pani uczniem/studentem college'u?** Tak ☐ Nie ☐

   Jeżeli tak: ☐ W pełnym wymiarze ☐ W niepełnym wymiarze Nazwa szkoły: _____

   Czy Pana/Pani ubezpieczenie studenckie obejmuje ubezpieczenie zdrowotne? Tak ☐ Nie ☐

   Jeżeli tak, prosimy podać:

   Posiadacz polisy: _____

   Ubezpieczyciel:_____

   Numer polisy: _____

   Prosimy dołączyć federalne zeznanie podatkowe rodziców za ostatni rok, załączniki i formularze W2

3. **Czy obecnie przyznano Panu/Pani bezpłatną opiekę medyczną lub zniżkę na usługi medyczne w innym szpitalu lub przychodni?**

   Tak ☐ Nie ☐ Jeżeli tak, gdzie? _____

POTWIERDZENIE ORAZ ZGODA

Niniejszym potwierdzam udostępnienie informacji zawartych w niniejszym wniosku organizacjom Northwestern Memorial Healthcare (NMHC) i/lub Northwestern Medical Faculty Foundation (NMFF) w celu określenia moich możliwości skorzystania z różnorakich programów pomocy finansowej, zgodnie z obowiązującą w wymienionych instytucjach polityką i procedurami. Upoważniam NMHC oraz NMFF do weryfikacji tych informacji w razie potrzeby, co może obejmować między innymi uzyskanie raportu Biura Informacji Kredytowej, sprawdzenia stanu faktycznego odnośnie zatrudnienia i dochodów, jak również kontroli dokumentów dołączonych do wniosku.

Wszelkie podane przeze mnie informacje oraz dokumenty poświadczające wysokość uzyskiwanych dochodów są prawdziwe, dokładne i kompletne. W przypadku ustalenia w dowolnym momencie, że przedstawione informacje są fałszywe i/lub niedokładne, wszelkie decyzje o przyznaniu prawa do bezpłatnej opieki medycznej zostaną cofnięte, a ja zobowiązuję się całkowitego i natychmiastowego zwrotu całej kwoty i wszelkich pozostałych należności.

Zobowiązuję się również do pokrycia wszelkich płatności, wymagalnych po przyznaniu dowolnej części zapomogi przeznaczonej na opłacenie świadczeń medycznych.

Podpis pacjenta/poręczyciela: _____ Data: _____

Northwestern Memorial Hospital

Solicitud para Programa de Asistencia Financiera

Entendemos que los gastos médicos a menudo no son planificados y, en caso de dificultades financieras, ayudamos a nuestros pacientes a explorar los recursos disponibles para pagar sus facturas médicas. Northwestern Memorial Hospital se asegura de que todos los pacientes reciban una atención de calidad sin tener en cuenta la capacidad individual de pago.

Northwestern Memorial Hospital ofrece una variedad de programas de asistencia financiera para satisfacer las necesidades de nuestros pacientes asegurados y no asegurados. Los programas de asistencia financiera incluyen cuidado gratuito y planes de pago con prórroga. Si se aprueba, este programa cubre los servicios médicos necesarios previstos por Northwestern Memorial Hospital y nuestra Sala de Emergencias. No se aplica a ningún otro cargo en que un paciente pueda incurrir. Para ayudarnos a determinar si usted califica para recibir asistencia financiera, por favor **llene, firme y devuelva** la solicitud junto con copias de cualquiera de los siguientes documentos de respaldo que tenga, incluidos:

- ☐ Licencia de conducir u otra identificación emitida por el estado
- ☐ Su declaración de impuestos, sus cédulas y sus formularios W2 más recientes

Si no ha presentado la declaración de impuestos, proporciónenos lo siguiente:

- ☐ Sus tres últimos recibos de pago de nómina u otro comprobante de ingresos
- ☐ Carta de indemnización del Seguro Social (ingresos o discapacidad)
- ☐ Carta(s) de otorgamiento financiero para cualquier tipo de préstamo o beca de estudios
- ☐ Carta de otorgamiento de beneficios por subsidio de desempleo

Envíe la solicitud y todos los documentos de suplementarios a:

Northwestern Memorial Hospital
Patient Financial Services
251 East Huron St., #2-304
Chicago, IL 60611

Una vez recibida su solicitud, se tomará una determinación y se le enviará una respuesta por escrito dentro de treinta (30) días de recibir su paquete de solicitud completo. Si tiene otras preguntas o necesita ayuda para llenar la solicitud, llámenos al 312-926-6906 o gratis al 800-423-0523.

Northwestern Memorial Hospital

Solicitud para Programa de Asistencia Financiera

Nombre del Paciente: _____ **Fecha de Nacimiento:** _____
Tamaño de la Familia: _____

Ingreso Anual del Solicitante: _____ **Ingreso Anual del Cónyuge o N/A:** _____

INFORMACIÓN DEL PACIENTE O DEL FIADOR

Nombre: _____ Relación con el Paciente**:** _____

Dirección Permanente: _____ Teléfono de Casa**:** ( ) _____

_____ **Teléfono Celular:** ( ) _____

¿Está usted empleado actualmente? Sí ☐ No ☐ ☐ Tiempo Completo ☐ Medio Tiempo

Nombre del Empleador: _____ Ocupación**:** _____

Dirección Permanente: _____ Teléfono**:** ( ) _____

_____

Si no tiene empleo, ¿ha estado usted (o su cónyuge) empleado en los últimos 6 meses? Sí ☐ No ☐

Dirección de Correo Electrónico: _____

¿Recibió servicios a través de la Sala de Emergencias? Sí ☐ No ☐

¿Está usted sin hogar? Sí ☐ No ☐

BIENES

1. **¿Es usted Propietario ☐ Alquila ☐ su residencia principal? ¿Cuál es su pago mensual?** _____
   Si usted es propietario, ¿cuál es el valor actual aproximado del mercado?_____
2. **¿Es usted propietario de otros bienes raíces?** Sí ☐ No ☐ _____
   En caso afirmativo, ¿cuál es el valor actual del mercado? _____
3. **¿Es usted propietario de un automóvil?** Sí ☐ No ☐ _____
   En caso afirmativo, ¿cuál es el valor actual del mercado? _____
4. **¿Tiene usted cuentas bancarias o de corretaje?** Sí ☐ No ☐
   En caso afirmativo, indique los nombres del banco/correduría:_____
   Saldo total en la cuenta: _____
5. **¿Es usted propietario de alguna de las siguientes opciones? (marque todas las que apliquen)**
   ☐ Acciones/Bonos valor actual:_____
   ☐ Certificados de Depósito valor actual:_____
   ☐ Otros Activos valor actual:_____

Northwestern Memorial Hospital

Solicitud para Programa de Asistencia Financiera

OTRO SEGURO

1. ¿Está cubierto por alguna póliza de seguro de salud, incluida la cobertura externa, Medicaid y Medicare?

Sí ☐ No ☐

En caso afirmativo, proporcione la siguiente información:

Titular de la Póliza: _____

Asegurador: _____

Número de la Póliza: _____

Titular de la Póliza: _____

Asegurador: _____

Número de la Póliza: _____

2. ¿Es usted estudiante universitario? Sí ☐ No ☐

En caso afirmativo: ☐ Tiempo Completo ☐ Medio Tiempo Nombre de la Escuela: _____

¿Tiene usted cobertura de atención médica a través del seguro de estudiante? Sí ☐ No ☐

En caso afirmativo, indique lo siguiente:

Titular de la Póliza: _____

Asegurador: _____

Número de la Póliza: _____

Incluya la declaración federal de impuestos más reciente de sus padres, así como las cédulas y formularios W2.

3. ¿Está aprobado actualmente para recibir Atención Gratuita o de Descuento en otro hospital o centro de salud de la comunidad?

Sí ☐ No ☐ En caso afirmativo, ¿dónde? _____

AUTORIZACIÓN Y CONSENTIMIENTO

Por la presente autorizo entregar la información que contiene esta solicitud al Northwestern Memorial Healthcare (NMHC) y/o Northwestern Medical Faculty Foundation (NMFF) para determinar mi condición de elegibilidad para los diferentes programas de apoyo financiero según las políticas y procedimientos de cada entidad. Autorizo a NMHC y NMFF a verificar esta información como sea necesario, lo que puede incluir, entre otras cosas, obtener un reporte del buró de crédito, verificación de empleo y/o ingresos y revisar los correspondientes documentos de soporte.

Toda la información y la documentación de ingresos que proporciono en esta solicitud son veraces, completas y correctas como se muestran. Si en algún momento se determina que la información que proporcioné resulta falsa o errónea, se rescindirán todos los subsidios para atención gratuita que se hayan otorgado y yo aceptaré la responsabilidad por el pago total e inmediato de cualquier saldo pendiente.

También estoy de acuerdo en aceptar la responsabilidad de pagar cualquier monto vencido después de haberse otorgado cualquier subsidio parcial para atención gratuita.

Firma del Paciente/Fiador: _____ Fecha: _____

Palos Community Hospital

12251 S. 80th Avenue | Palos Heights, IL | 60463 | (708) 923-4000
www.paloscommunityhospital.org

- No link for financial assistance from home page; used search engine for "financial assistance" which brings you to the page.
- Has link for "Pay Your Bill" from home page.
- "Financial Assistance Application" is available to download from website.
- Online financial assistance text:

Financial Assistance

Palos Community Hospital offers a variety of payment alternatives such as discounts, interest free payment plans, assistance with enrollment for State and Federal Programs along with our own Financial Assistance Program. Contact a Financial Counselor to discuss your particular financial situation. You may download the Financial Assistance Application and mail in the completed application.

Financial Counseling

To arrange for financial counseling, call (708) 923-4585. There is no charge for this service.

Medicare Assistance

Seniors who need help filling out Medicare forms can contact our Senior Resource representative at (708) 923-4785. Appointments are required. There is no charge for this service.

Palos Community Hospital
Request for Financial Assistance

Patient Name: _____ Date: _____

Guarantor Name: _____

Account Number(s): _____ _____ _____

Total Balance Due: $ _____

In order to properly evaluate your need for financial assistance, please complete the following:

1. Please fully complete and sign the attached financial statement.
2. Submission of the following documents along with the completed application.
    a. A copy of your most recent tax forms with corresponding W-2 forms.
    b. A copy of your paycheck stubs and your spouse's paycheck stubs for the last three pay periods if applicable.
    c. A copy of your award letter from Social Security.
    d. Copies of your unemployment checks.
    e. If you are a full time student, please provide proof of enrollment.
    f. Please provide a letter/written statement explaining your need for financial assistance.
    g. A notarized signature of person(s) assisting with living conditions or financial assistance.

Please forward the completed application and all documentation to:

Director of Patient Financial Services
Palos Community Hospital
12251 S. 80th Avenue
Palos Heights, IL 60463

If you have any questions regarding the form, please contact the Business Office at our toll free number (866) 395-4723.

Financial Application

Please fill out application completely and to the best of your knowledge.

Name (First, Middle, Last)		Date of Birth	Social Security Number
Home Address (include apt. #)	City	State	Home Phone Number
Employer's Name	Position	Employer's Address	
Employer's Phone ( )	Employment Length Years Months	Monthly Gross Salary $	

Spouse's Name (if applicable)

Name (First, Middle, Last)		Date of Birth	Social Security Number
Employer's Name	Position	Employer's Address	
Employer's Phone ( )	Employment Length Years Months	Monthly Gross Salary $	

If there is no income, send notarized proof of living conditions and any financial help received from any source other than those mentioned in this document. A notarized signature of person(s) assisting with living conditions or financial assistance other than those mentioned in this document is required.

Source of Other Income (Please indicate Monthly Amount)

Social Security	$	Alimony/Child Support	$
Pensions (list each) 1. 2. 3.	$	Interest/Dividend (list) 1. 2. 3.	$
Unemployment	$	Rental Income (house and land)	$
Public Assistance	$	Other (please explain)	$

Additional Information Regarding Finance

Property Other Than Home Dwelling (Exclude business and rental property) Describe type of property including farm land, undeveloped land, etc.	Automobiles (List model, make and year of all autos.)	
Value of Property: $	Checking Account Number and Average Balance: $	
Amount Owed On Property: $ Other Property: Value of Property: $ Amount Owed on Property: $	Savings Account Number and Average Balance: $ Name of Bank(s) 1. 2.	
Location of Property(s) 1. 2.	Address of Bank(s) 1. 2.	
If you are not employed, are you ☐ Disabled ☐ Retired ☐ Student	Non Retirement Accounts:	Stocks/Bonds: $
If you are a full-time student list the name and and phone number of the school.	Certificates of Deposit: $	

List dependent children and attach proof of dependency if child is over age of 18.

Name	Relationship	Birthdate	Months in Applicant's Home

Monthly Obligations:

Rent/House Payment	$	Recreation/Entertainment	$
Light & Heat	$	Car Insurance (monthly)	$
Water & Sewer	$	Doctor/Dentist/Medical	$
Garbage Removal	$	Books/Magazine/Newspaper	$
Telephone	$	Food & Household Supplies	$
Clothing	$	Medical Insurance	$
Car Payment	$	Life Insurance	$
Cable TV	$	Rent/House Insurance	$
School Expense	$	Miscellaneous (explain)	$
Charities	$	**TOTAL MONTHLY OBLIGATIONS**	$

Creditors (i.e. credit cards, auto, medical, etc.) Attach copies of medical.

Name & Address of Creditor	What was purchased?	Amount Financed	Unpaid Balance	Monthly Payments

I/We hereby certify that I/we are of legal age and that the forgoing statements are true and complete and are made for the purpose of determining my/our eligibility for financial assistance. I/We agree that this statement shall remain your property, whether or not the application is accepted. I/We agree to provide the necessary verification of my/our income and authorize you to make all inquiries that you deem necessary to verify the accuracy of the statements made therein, and to determine my/our credit worthiness, including, but not limited to procuring consumer reports from consumer reporting agencies, and credit information from bank and other financial institutions and expenders of credit, references, present and former employers, merchants, landlords and creditors.

Signature of Applicant _____ Date _____

Signature of Spouse (if applicable) _____ Date _____

Palos Community Hospital

12251 S. 80th Avenue • Palos Heights, Illinois 60463 • (708) 923-4000

For your convenience, please use this page to write your statement explaining your need for financial assistance. You may also use this page for your notarized statement of proof of living conditions.

_____ _____

Signature of Patient/Guarantor Date

Signed and sworn to before me this _____ day of _____ 20___.

_____

Notary Public

Resurrection Health Care

7435 W. Talcott Ave. | Chicago, IL | 60631-3707 | (877) RES-INFO
www.reshealth.org

- Has link for "Financial Assistance" from home page.
- Has information on financial assistance and applications in English, Spanish, Polish, Italian and Russian.
- Has financial counselors that speak Spanish and Polish.
- Has "A Guide to Our Financial Assistance and Billing Process available in English, Spanish, and Polish.
- Online financial assistance text:

Our Financial Assistance Policy

Resurrection Health Care has a variety of financial assistance and charity care options for eligible community members. If you have any questions regarding your eligibility for the RHC financial assistance and charity care, the Illinois Uninsured Patient Discount Act or any other insurance, billing or payment issue, please call our financial counselors.

What Is Financial Assistance?	*En Español*	*Po Polsku*		
Do I Qualify for Financial Assistance?	*En Español*	*Po Polsku*		
Apply for Financial Assistance	*En Español*	*In Italiano*	*Po Polsku*	*Русскмй*

Financial Counselor Contact Information

Please call us if you have any questions about financial assistance and charity care, the Illinois Uninsured Patient Discount Act, or any other insurance, billing or payment issue.

- *En Español* *Po Polsku*

Related Information

A Guide to Our Financial Assistance and Billing Process - Overview of financial assistance, plus billing and payment information for patients with Medicare, Medicaid or other insurance coverage.

- *En Español* *Po Polsku*

Illinois Uninsured Patient Discount Act - effective for service dates April 1, 2009 and after.

Free services to help you get the right health care

- *RES-INFO Nurse Advice Line and Physician Referral*
- *Health Access Service*

Community Clinics

Resurrection Health Care offers accessible, affordable health care through its community clinics.

RESURRECTION HEALTH CARE
APPLICATION FOR FINANCIAL ASSISTANCE

Dear Patient,

Thank you for choosing a Resurrection Health Care hospital for your health care needs. We are committed to improving the health and well being of everyone in our community. We are pleased to offer our financial assistance and charity care program to help individuals and families who need assistance.

Enclosed is our Financial Assessment form. Please return the completed form with the requested documents by: _____. If you have questions about the documents or do not have all the documents, please contact the Financial Counselor at the phone number below. They will gladly assist you. Thank you for your cooperation.

Documents Requested for Determination of Eligibility for Financial Assistance
(Please provide documents from each category as applicable.)

Photo ID / Proof of Identification (one document required)

- Current Driver's License or State ID
- Current Student or Employee ID Card
- Current Passport
- Current Permanent Resident Card (Green Card)
- Current Matricula Consular

Proof of Income (for each household member, provide all documents that exist and/or apply)

- Pay stubs / proof of tips for past 2 months
- If paid in cash, a signed letter from employer indicating terms of employment, including wages/salary, dates of employment, current employment status, the availability of any health care benefits, etc.
- If self employed, business records including income, expenses, liabilities and assets for past 2 months
- Copies of checks or award letters from unemployment, Social Security or Veterans Administration
- Copies of checks for child or spousal support
- Proof of other income (for example, interest income, pension, rental income)
- Copy of income tax return from most recent filing period
- Notarized Confirmation of Support Letter

Disclosure of Assets (for each household member, provide all documents that apply)

- Current statement from Checking and Savings Account(s), Certificate(s) of Deposit, Money Market Fund, Trust Fund or Brokerage Statement

Please submit the requested documents to: **Financial Counselor, St. Elizabeth Campus, 1431 N. Claremont, Chicago, IL 60622-9882**. Determinations of Eligibility for Financial Assistance are made within fifteen business days after receiving **all** of the requested documents.

Completion of this form is not a guarantee of eligibility for Financial Assistance /Charity Care, or any other program. Financial Assistance /Charity Care is only considered after all possible sources of coverage or potential payment (for example, health insurance, Medicare, Medicaid, All Kids, liability insurance) have been exhausted. Failure to provide all requested documents will result in non-approval.

If you have any questions, please call: _____ _____
Name Phone Number

Thank you,

Financial Assistance Counselor
Patient Financial Services

Date: _____ Application #: _____

RESURRECTION HEALTH CARE
FINANCIAL ASSESSMENT FORM

Patient's Name: _____

Applicant's
Last Name _____ **First Name** _____ **M.I.** _____ **Relationship to Patient**_____

DETERMINATION OF HOUSEHOLD SIZE

(Please include names and relationship to applicant of all dependents claimed on most recent income tax filing and household members living in applicant's home.)

Spouse _____ **Rel** _____ **Household Member**_____ **Rel**_____

Household Member_____ **Rel** _____ **Household Member**_____ **Rel**_____

Household Member_____ **Rel** _____ **Household Member**_____ **Rel**_____

DISCLOSURE OF INCOME AND ASSETS

(Please complete each line that applies to you and your household members.)

Applicant's Income Information (please provide for each employer)

Employer Name:_____ **Phone:**_____ **For Office Use Only**

Address:_____ **Length of Employment:**_____

_____ **Gross Income $:**_____
(Circle One: Wkly, Biwkly, Monthly) **$**_____**A**

Spouse's Income Information (please provide for each employer)

Employer Name:_____ **Phone:**_____

Address:_____ **Length of Employment:**_____

_____ **Gross Income $**_____
(Circle One: Wkly, BiWkly, Monthly) **$**_____**B**

Household Member's Income Information (please provide for each employer)

Employer Name:_____ **Phone:**_____

Address:_____ **Length of Employment:**_____ **$**_____**B**
_____ **Gross Income $**_____

(Circle One: Wkly, BiWkly, Monthly)

Income – Other Sources:

Child Support **$**_____ **Pension Plan $**_____

Interest Payments: **$**_____ **Other $**_____ **$**_____**C**

Bank/Savings & Loan Account Balances

Checking Account $_____ **Savings Account $**_____

Checking Account $_____ **Savings Account $** _____

IRA/Certificates of Deposit $_____ **Trust Fund Account $**_____ **$**_____**D**

IF ALL YOUR INFORMATION DOES NOT FIT ON THIS SHEET, PLEASE COPY THIS SHEET AND PROVIDE THE INFORMATION ON THE COPY.

_____
Sender's Initials and Date Sent

DOCUMENT CHECKLIST
(Please provide copies of documents from the lists below.)

☐ **Photo ID / Proof of Identification (one document required)**

- Current Driver's License or State ID
- Current Student or Employee ID Card, with photograph
- Current Passport
- Current Permanent Resident Card (Green Card)
- Current Matricula Consular

☐ **Proof of Income (provide copies of all documents that exist)**

- Pay stubs / proof of tips for past 2 months
- If paid in cash, a signed letter from your employer indicating the terms of employment, including wages/salary, dates of employment, current employment status, the availability of any health care benefits, etc.
- If self employed, business records including income, expenses, liabilities and assets for past 2 months
- Copies of checks or award letters from unemployment, Social Security or Veteran's Administration
- Copies of checks for child or spousal support
- Proof of other income (for example, interest income, pension, rental income)
- Copy of income tax return from most recent filing period
- Notarized confirmation of support letter

☐ **Disclosure of Assets (provide all documents that apply)**

- Current statement from Checking and Savings Account(s), Certificate(s) of Deposit, Money Market Fund, Trust Fund or Brokerage Statement

I understand that qualifying for financial assistance is based on Resurrection Heath Care's ability to verify the information I have provided. I hereby certify, by signing below, that the information and documentation provided by me is complete and accurate to the best of my knowledge.

Applicant's Signature	**Date**	**Spouse's Signature**	**Date**
Applicant's Social Security Number		**Spouse's Social Security Number**	
Address		**City**	
State	**Zip code**	**Home Telephone Number**	

☐ **Application Mailed to Patient** ☐ **Application Hand Delivered to Patient** ☐ **Application Completed Over Phone**

Date Logged: _____/_____/_____ **Logged by:** _____

RESURRECTION HEALTH CARE
Confirmation of Support Letter

_____
Applicant (Print)

_____
Application Number

The person named above applied for financial assistance to pay their hospital bill and has advised us that you either contribute substantially to their support or you are their sole means of support. Please complete this form, have it notarized and return it in the enclosed self-addressed envelope by: _____. For assistance finding a Notary Public, please consult the Illinois Secretary of State's Office at **http://www.ilsos.gov/notary/** or by calling 1-800 252-8980.

Note: Completing this form does not mean that you will be responsible for the patient's hospital Bill

Thank you.

The type of support I / we provide is: (please complete all that apply)

_____ Room and Board, since (date) _____

_____ Allowance of $ _____

every week ____, every 2 weeks ____, every month ____

_____ Other (please explain) _____

_____

I / We, (print) _____ have been the sole/substantial support for the person named above and, to the best of my / our knowledge, declare that this person has no other primary means of support.

_____	_____
Signature 1	Signature 2 (if jointly providing support)
_____	_____
Relationship to Applicant	Relationship to Applicant
_____	_____
Address, Street	City
_____	_____
Telephone	Date

Subscribed and sworn before me this _____ day of _____, A.D.

_____
Notary Public

Roseland Community Hospital

45 W. 11th Street | Chicago, IL | 60628 | (773) 9953000
www.roselandhospital.org

- Has link for "Financial Assistance" from home page
- Has link to Charity Care application form (pdf)
- Online financial assistance text:

Roseland Community Hospital is committed to providing compassionate health care to all. In keeping with the hospital's commitment to serve all members of its community, RCH recognizes and acknowledges there are patients who are unable to afford the charges associated with their medical care.

*If you do not have health coverage for services or your health insurance coverage is not sufficient to cover the services rendered, RCH discuss payment options or other programs that might be available to you. These may include state (*e.g., *Medicaid, All-kids), federal programs (*e.g., *Medicare), or RCH's financial assistance program.*

Download Charity Care Application Form *(PDF)*

For more information or questions please contact our Patient Financial Services Department.

Patient Accounts Department
Roseland Community
45 West 111th Street
Chicago, IL 60628

Credit Assistant Information
Contact Derrielia Williams, Financial Counselor at ext 3108.

Monday through Friday 9:00 a.m. to 4:00 p.m. (excluding holidays)

45 West 111th Street
Chicago, Illinois 60628
773-995-3000

Charity Assistance Application - Hospital Services *Only*

Instructions: Please complete application and sign. Any incomplete applications will be returned.

Patient information

Last name	First name	Birthdate	Social Security number

Street	Apt number	City	State	Zip	Home phone

Employer	Employer's address	Work phone	Cell phone

City	State	Zip	Position

Guarantor's primary bank	Address	City/State

Parent/Spouse information (if patient is a minor)

Last name	First name	Birthdate	Social Security number

Street	Apt number	City	State	Zip	Home phone

Employer	Employer's address	Work phone	Cell phone

City	State	Zip	Position

Guarantor's primary bank	Address	City/State

Income information

Please list all income below. Include spouse's income, rental income, Social Security, unemployment compensation, worker's compensation, veteran's payments, insurance or annuity income, dividends, etc. Attach an additional sheet if more lines are needed. Provide copies of last pay stub, or income records, and most recent federal tax return with W-2s.

Income Received	Received from	Gross amount
☐ Weekly ☐ Bi-weekly ☐ Monthly		
☐ Weekly ☐ Bi-weekly ☐ Monthly		

Expenses

Rent/mortgage: **Utilities:**

Medical expenses:

Number of dependents: **Please use back side to list members of family living in the household**

Attach copies of any outstanding medical bills, utility bills or other expenses you would like considered in the determination. Please list any unusual circumstances that are not reflected in the income section that you would like us to consider on the back of this form, or on a separate piece of paper such as a recent loss of job or income.

Support statement: If you reported $0.00 income, please have this section completed by the person(s) helping you.

I am assisting the patient by providing room and board, but I am not responsible for payment of his/her medical bills.

Print name	Length of time providing room/board to patient
Signature	Relationship to patient

Patient/Guarantor statement:

I certify that the above information is true and complete to the best of my knowledge. Applicant(s) authorize Roseland Community Hospital to verify address, employment and credit history.

Patient/Guarantor Signature: _____ **Date:** _____

Patient Name

Please give us any additional information that you feel we need to make a determination for your application for assistance. These may include, but are not limited to, recent loss of job or income, unusual medical bills from other providers (please provide copies of bills), school tuitions. Please include some detail, as we may ask for verification of these details.

Family/members of household

Name	Age	Relationship

Please use a separate piece of paper, if needed.

Rush University Medical Center

1653 W. Congress Parkway |Chicago, Illinois, 60612 |(312) 942-5000
www.rush.edu/rumc

- Has link for "Financial Assistance Programs" from the home page
- Has application for financial assistance eligibility online
- Has current Federal Poverty Guidelines link
- Has "Federal Register Documentation on Charity Care" .pdf available
- Online financial assistance text:

In keeping with Rush University Medical Center's mission to provide comprehensive, coordinated health care services to our patients, Rush offers several financial assistance programs to help patients with their hospital bills.

To help patients decide which is the right program for them, Rush offers the services of financial counselors and billing customer service representatives. These individuals will assist patients in completing financial application forms, obtaining an estimated cost of anticipated hospital services, and providing an explanation and copy of their hospital bill.

- *Financial Assistance (Charity Care)/Full Write-Off*
  After the financial counselor or customer service representative performs a financial assessment, the hospital bill can be discounted up to 100 percent if the patient's income is 300 percent of the Federal Poverty Guidelines (family size adjusted) or less.

- *Limited Income Program*
  After a financial assessment of the patient's income has been completed, the hospital will provide services at cost if the patient's income level meets the appropriate criteria. For fiscal year 2010, the Limited Income Discount criteria for family income is 400 percent of the Federal Poverty Guidelines. The Limited Income Discount is 70 percent.

- *Self-Pay Discount*
  For Illinois residents, a 64 percent discount will automatically be given to all self-pay patients unless a Global Case Rate is applicable. Out-of-state residents automatically receive a 50 percent discount, which is equivalent to Rush's average managed care discount.

- *Payment Plan*
  Patient can arrange for time payments with a financial counselor or customer service representative. After a financial assessment, the appropriate monthly payment will be assigned within a prescribed time frame.

To be evaluated for financial assistance programs, download and complete the Request for Determination of Eligibility for Financial Assistance (Charity Care). After filling out the form, please mail it to Customer Service at 1700 W. Van Buren, Suite 161, Chicago, IL 60612.

Current Federal Poverty Guidelines

Federal Register Documentation on Charity Care

If you have any questions regarding a discount or payment plan, please call a financial counselor at (312) 942-5967. If you have already received services at Rush University Medical Center, please call a customer service representative at (312) 942-5693 or toll-free at (866) 761-7812.

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE PROGRAM: FINANCIAL STATEMENT

I hereby request that Rush University Medical Center evaluates the following financial information in regards to my possible eligibility for a Financial Assistance Program for hospital-based services (non-professional fees) through the Medical Center.
I understand that the information I provide concerning the annual income and size of my household is subject to verification by the Medical Center. I also understand that if any portion of the information I have provided is determined to be falsified, I will be responsible for all medical expenses incurred at this institution.

1) Demographic Information

NAME: _____
Last First Middle Int.

ADDRESS: _____
Number and Street Apt.

_____
City State Zip Code

PHONE: ( ) _____

DATE of BIRTH: ____/____/____

SOCIAL SECURITY NUMBER: _____-_____-_____

2) Income Information

- Please enclose your most recent W-2 forms, Income Tax Return, or Unemployment/Social Security statements (past 3 months)

	TOTAL (past 3 months)	TOTAL (past 12 months)
• Wages Earned	_____	_____
• Public Assistance	_____	_____
• Social Security	_____	_____
• Unemployment Comp	_____	_____
• Workmen's Compensation	_____	_____
• Strike Benefits	_____	_____
• Alimony Received	_____	_____
• Child Support Received	_____	_____
• Military Family Allotments	_____	_____
• Pensions	_____	_____
• Income from:		
◦ Dividends	_____	_____
◦ Interest	_____	_____
◦ Rent	_____	_____
• Other	_____	_____

RUSH UNIVERSITY MEDICAL CENTER

3) Employment Information

OCCUPATION: _____

EMPLOYER: _____ PHONE: ( ) _____

* If not employed, date last worked ____/____/____

4) Family Size Information

Total Number in Household*: _____

(*Number of individuals for whom you are financially responsible)

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5) Type of Medical Service(s) Provided:

_____

_____

I affirm that the information that has been provided in this Financial Statement is true and correct to the best of my knowledge.

_____ ____/____/____

Signature of Person Making Request Date

_____ ____/____/____

Rush Financial Counselor/Representative Date

Saint Anthony Hospital

2875 W. 19th Street | Chicago, IL 60623 | (773) 484-1000 | www.cath-health.org
Financial Assistance Department: (773) 484-4217

- Has link for "Financial Assistance" from the home page
- Has link to Download Patient Financial Assistance form .pdf
- Online financial assistance text:

Saint Anthony Hospital provides financial assistance to patients who are unable to pay their financial obligations associated with services they receive from the Hospital.

Financial Assistance & Uninsured Discounts
Faithful in its service to the community, Saint Anthony Hospital provides financial assistance to patients who are unable to pay their financial obligations associated with services they receive from the Hospital.

If you have need for healthcare services, but lack the means to pay and believe you may qualify, please complete and submit the application for Patient Financial Assistance (PDF: 2 pages / 473 KB). Qualified patients will have all or part of their hospital bills forgiven. If you do not qualify for Financial Assistance, but are uninsured, your account will be automatically discounted 58% of the total charges.

Additionally, Saint Anthony Hospital's financial counselors will work with patients and their families to assist them in finding other means for health coverage.

For questions, please contact the Financial Assistance Department at (773) 484-4217.

Saint Anthony HOSPITAL
Dedicación, nuestro compromiso

The following documentation is needed in order to process the Charity Care application for Saint Anthony Hospital.

- **Identification.** (driver's license, passport, SS card, Etc.)
- **Proof of income.**
  W2's, previous year income tax returns Federal and State,
  unemployment benefit checks (If recently unemployed)
  Last 4 check stubs
  Social Security benefits letter (If retired)
  Savings account balances.
- **Letter of support.** (If not employed) notarized.
- **Proof of dependents.** (if not listed on tax forms)
  Birth Certificate, Social Security card or Identification.

Copies of the above documents are required, original documents will not be returned. If you have any questions please feel free to contact us at 773.484.4800 from 8:30 AM to 3:30 PM Monday thru Friday.

PLEASE MAIL ALL THE DOCUMENTATION TO:
SAINT ANTHONY HOSPITAL
1849 PAYSPHERE CIRCLE
CHICAGO, ILLINOIS 60674
ATTN: CUSTOMER SERVICE REP.

SAINT ANTHONY HOSPITAL
CHARITY CARE ASSISTANCE APPLICATION

DATE: _____/_____/_____ **RETURN BY _____/_____/_____**

PATIENT NAME:_____ **TELEPHONE: (_____)_____-_____**

GUARANTOR:_____ **TELEPHONE: (_____) _____-_____**

ACCOUNT BILLING NUMBER (S)

DATE OF SERVICE:_____/_____/_____

PATIENT'S BALANCE DUE $ MR#

Source of income

☐ **Employed** ☐ **Disability** ☐ **Social Security**

☐ **Child Support** ☐ **Alimony** ☐ **Unemployment Compensation**

☐ **Other** _____

Amount of total annual combined income: $

Employer's Name: _____ **Spouse's Employer** _____
Address: _____ **Address:** _____
_____ _____
Phone Number: _____ **Phone Number:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorsed**

Dependents	Name		Social Security Number
1			
2			
3			
4			
5			
6			
7			

ADDITIONAL COMMENTS:

IN THE SPACE PROVIDED BELOW, PLEASE PROVIDE ANY ADDITIONAL COMMENTS/INFORMATION WHICH MAY ASSIST IN OUR ASSESSMENT OF YOUR FINANCIAL SITUATION:

_____

_____

_____

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENT(S) ARE TRUE. I AUTHORIZE SAINT ANTHONY HOSPITAL TO MAKE ANY INQUIRIES NECESSARY TO VERIFY THEIR ACCURACY.

PATIENT'S SIGNATURE_____ **DATE**_____

HOSPITAL USE:
APPROVED % _____ **Date** _____

DENIED/REASON _____ **Date** _____

St. Bernard Hospital and Health Care Center

326 West 64th Street | Chicago, IL 60621 | (773) 962-3900
www.stbh.org

- Has link for "Financial Assistance Programs" from the home page
- Has link to Download Charity Care Application form .pdf
- Online financial assistance text:

Financial Assistance

Download Charity Care Application Form (PDF)

St. Bernard Hospital is committed to providing compassionate health care to all. In keeping with the hospital's commitment to serve all members of its community, St. Bernard recognizes and acknowledges the financial needs of patients who are unable to afford the charges associated with their medical care. If you do not have health coverage for services, or your health insurance coverage is not sufficient to cover the services rendered, our Credit Assistants will review payment options or other programs that might be available to you. These may include state (such as Medicaid, Kidcare, Illinois Crime Victim), federal programs, or St. Bernard Hospital's financial assistance program. We will be happy to assist you in determining if you qualify for any of these programs. Or, you may return the completed application to our office,

Patient Accounts Department
St. Bernard Hospital
326 West 64th Street
Chicago, IL 60621

For more information or questions please contact our Patient Financial Services Department.

Credit Assistant Information
773-962-4421 (patient's last name beginning with A thru M)
773-962-4011 (patient's last name beginning with N thru Z)
Monday through Friday 9:00 a.m. to 4:00 p.m. (excluding holidays)

ST. BERNARD HOSPITAL
AND HEALTH CARE CENTER
326 West 64th Street • Chicago, Illinois 60621
773-962-3900

Charity Assistance Application - Hospital Services *Only*

Instructions: Please complete application and sign. Any incomplete applications will be returned.

Patient information

Last name	First name	Birthdate	Social Security number		
Street	Apt number	City	State	Zip	Home phone
Employer	Employer's address		Work phone		Cell phone
City	State		Zip	Position	
Guarantor's primary bank	Address	City/State			

Parent/Spouse information (if patient is a minor)

Last name	First name	Birthdate	Social Security number		
Street	Apt number	City	State	Zip	Home phone
Employer	Employer's address		Work phone		Cell phone
City	State		Zip	Position	
Guarantor's primary bank	Address		City/State		

Income information

Please list all income below. Include spouse's income, rental income, Social Security, unemployment compensation, worker's compensation, verteran's payments, insurance or annuity income, dividends, etc. Attach an additional sheet if more lines are needed. Provide copies of last pay stub, or income records, and most recent fereal tax return with W-2s.

Income Received	**Received from**	**Gross amount**
☐ Weekly ☐ Bi-weekly ☐ Monthly		
☐ Weekly ☐ Bi-weekly ☐ Monthly		

Expenses

Rent/mortgage: **Utilities:**

Medical expenses:

Number of dependents: **Please use back side to list members of family living in the household**

Attach copies of any outstanding medical bills, utitility bills or other expenses you would like considered in the determination. Please list any unusual circumstances that are not reflected in the income section that you would like us to consider on the back of this form, or on a seperate piece of paper such as a recent loss of job or income.

Support statement: If you reported $0.00 income, please have this section completed by the person(s) helping you.

I am assisting the patient by providing room and board, but I am not responsible for payment of his/her medical bills.

Print name	**Length of time providing room/board to patient**
Signature	**Relationship to patient**

Patient/Guarantor statement:

I certify that the above information is true and complete to the best of my knowledge. Applicant(s) authorize St. Bernard Hospital and Healthcare Center to verify address, employment and credit history.

Patient/Guarantor Signature: _____ **Date:** _____

Patient Name

Please give us any additional information that you feel we need to make a determination for your application for assistance. These may include, but are not limited to, recent loss of job or income, unusual medical bills from other providers (please provide copies of bills), school tuitions. Please include some detail, as we may ask for verification of these details.

Family/members of household

Name	Age	Relationship

Please use a seperate piece of paper, if needed.

Swedish Covenant Hospital

5145 N California Avenue | Chicago, Illinois 60625 |773.878.8200 |TTY 773.989.4855
www.swedishcovenant.org

- No link for financial assistance from home page; used search engine for "financial assistance" and "charity care" (both worked)
- Links to download "Charity Care Policy" and "Financial Application" on the Charity Care Policy page in multiple languages are available
- Online Charity Care Policy text:

Home » About Us » History and Mission » Charity Care Policy

Charity Care Policy

We offer assistance in paying for necessary medical services to eligible patients with limited financial means. These health care services are provided with no expected reimbursement or at reduced levels, based upon established criteria, recognizing the need to maintain the dignity of the individual during the consideration process.

For more information, we invite you to download and review the Swedish Covenant Hospital ***Charity Care Policy*** *or to visit our Credit Services Department (Galter Medical Pavilion, first floor, 8:30 a.m. to 5 p.m. Monday through Friday) or call us at (773) 989-3841.*

- *English Greek Korean Russian Spanish Urdu*

Eligibility for charity care requires the completion of a ***Financial Application****.*

- *English Greek Korean Russian Spanish Urdu*

In addition to charity care, Swedish Covenant Hospital offers assistance with registering for FamilyCare and KidCare health insurance for low income children, parents and expecting mothers. To learn more, visit our ***FamilyCare and KidCare pages****.*

Swedish Covenant Hospital

The science of feeling better

DEPARTMENT 02 Patient Financial Services

COST CENTER 906+

POLICY 07 Guidelines for Issuing Charity or Discounted Care

REVIEWED BY: Raymond Vieth, Vice President, Finance

APPROVED BY:

Signature | President and CEO (Title) | 8-1-10 (Date)

EFFECTIVE DATE: June 8, 1993

REVISED: 9/22/04; 1/26/05; 11/16/05; 6/22/06; 1/24/07; 8/6/08; 5/19/09, 6/01/10; 8/01/10

REVIEWED: 9/16/99; 9/23/02; 8/11/04

PURPOSE: To ensure policy and procedures exist for identifying those patients for which service is to be rendered free of charge, or at substantial discount, based solely on ability to pay and financial condition of the eligible beneficiary.

PHILOSOPHY:

Swedish Covenant Hospital, in keeping with the mission of the Evangelical Covenant Church, serves the medical needs of the community, regardless of race, creed, color, sex, national origin, sexual orientation, handicap, residence, age, ability to pay, or any other classification or characteristic. Swedish Covenant Hospital recognizes the need to render care to the sick who do not possess the ability to pay for their services. These health care services will be provided with no expected reimbursement, or reduced levels, based upon established criteria, recognizing the need to maintain the dignity of the individual during the consideration process. In recognizing the need to deliver uncompensated care, Swedish Covenant Hospital expects all patients with the ability to pay, to meet their financial obligations in a timely and efficient manner, in accordance with the institution's collection policies.

Definition of Terms - For purpose of this policy, the following terms will be defined in order to carry out the purpose established above.

Charity (free) or Discounted Care:
Health care services provided that were not expected to result in the generation of payment in full, in accordance with procedures established in this policy. This does not include contractual allowance amounts between hospital gross charges and contracted third party reimbursement rates.

Bad Debt Expense:
Health care services provided that were expected to result in the generation of payment of services, but due to the patients' unwillingness to meet their financial obligation, resulted in non-collection of those services.

Insurance Payments:
Health care services that were expected to result in the generation of payment of services from Medicare, Medicaid, Blue Cross, HMO's, PPO's, and any other valid and qualifying insurance that the patient

possesses. This includes any valid supplemental insurance to meet deductible and co-insurance payments required by insurance providers described above.

Patients Without Insurance (Uninsured Patients):
Patients requiring medically necessary services who are not covered by or eligible for Medicare, Medicaid, HMO's, PPO's or other third party payers at the time healthcare services are provided.

PROCEDURE:

Determination of Eligibility for Charity or Discounted Care

1. Charity or discounted care is available for medically necessary services as defined by Medicare, to patients who meet the financial and documentation criteria defined below. Each situation is reviewed on an individual case by case basis. While not absolutely essential, the need for potential charity or discounted care should be established in advance of admission or rendering of service, or shortly thereafter.

2. In order to be eligible for charity or discounted care, the patient must be willing to provide verification of income, assets, etc. by filling out the Patient Financial Statement attached as Exhibit 1.

3. During the registration and information gathering process, the financial counselors will first determine if the patient qualifies for medical assistance from other existing financial resources such as Medicare, Medicaid, Kid Care, Family Care or other state or federal programs. If the patient refuses to apply for existing financial resources or to provide information necessary to the application process, charity or discounted care cannot be granted. If the application for existing financial resources is denied, or has been previously denied, consideration for charity or discounted care will then be given.

4. Once the information on the Patient Financial Statement (Exhibit 1) is received, the financial counselors will determine the eligibility of the patient for charity or discounted care. SCH will suspend the collection process while the charity care application is being reviewed. In evaluating the data, considerations will be given to assets (saving accounts, ownership of home), income and current indebtedness. Documentation of income may be required in the form of paycheck stubs, income tax returns, social security, and unemployment benefits. Information used to apply for state or local assistance will also be used in the determination process.

5. The insured patient with a large balance due to deductibles and/or co-payments may be eligible for charity or discounted care. In order to qualify, the patient must complete the Patient Financial Statement and return it to the financial counselors for evaluation and recommendation.

6. If a patient has been determined to meet the Hospital Charity Care Guidelines no collection agencies, lien attachments or attempts to possess real or personal property will be made.

7. No legal action will be taken against uninsured patients for the first one hundred twenty (120) days after discharge.

Approval of Charity or Discounted Care

1. To insure that the determination of charity or discounted care receives appropriate levels of consideration, the following approval guidelines and levels will be followed:

Charity or Discounted Care	Appropriate Personnel
$1 - $9,999	Manager of Credit Services
$10,000 - $50,000	Director, Patient Financial Services
$50,000 and above	Vice President, Finance

2. Patients who have a family income that is no more than 600% of the Federal Poverty Guidelines (as determined each year), and who do not have any health insurance as documented through SCH's insurance verification procedures, will receive a discount in accordance with the Hospital Uninsured Patient Discount Act (ILCS 210 89/) (the Act).

For medically necessary services, charges will be discounted to 135% of Medicare cost with the discount applicable to charges greater than $300.00. The maximum amount collectible in a 12-month period from a patient without insurance will be 25% of the family's annual gross income. Additionally, for patients without insurance, the Hospital will limit the maximum out-of-pocket liability to $15,000.00 per eligible service.

For services excluded by the Act, i.e., elective cosmetic surgery, the Hospital may provide a discount from billed charges based on the patient's ability to pay, as verified through Hospital procedures.

3. For medically necessary services, one hundred percent (100%) charity will be provided for patients with a family income at or below 150% of the Federal Poverty Guidelines as verified through Hospital procedures.

4. Should the application be denied, the patient will be permitted to appeal the decision by providing additional information within thirty (30) days of receipt of notice. The appeal will be reviewed by SCH's Chief Financial Officer, who will provide a final decision within fifteen (15) days after receipt of the request.

Documentation and Recording of Charity or Discounted Care

In order to quantify the level of charity care, a log will be maintained documenting the total value of all charity or discounted care. This log will be available for inspection by any government agency requiring levels of charity or discounted care as part of Swedish Covenant Hospital maintaining the exemption from federal, state, or local taxes.

Ratified and approved by the Board of Directors, June 16, 2010
Effective: August 1, 2010

Swedish Covenant Hospital

The science of feeling better

DATE

Dear _____(Patient/head of household)

Thank you for choosing Swedish Covenant Hospital (SCH) for your health care needs. We offer financial assistance to help people of limited financial means. SCH has developed financial policies to facilitate this process. **A social security number is not required to apply for financial assistance.**

Information about your income and family size are important in determining if you are eligible for any financial assistance from Swedish Covenant. Please answer the questions on the reverse side of this page to the best of your ability. Also, provide any evidence you have to support your information, using the examples named below:

1. **About your income.** Examples of supporting documents: (provide any that fit your situation) – current paystubs, receipts from self-employment, copies of unemployment checks, copies of social security checks, any other written document. If your employer(s) pay you in cash, state your earnings in writing in this application for the past two pay periods.

2. **About the size of your family (household).** Provide the names and relationship of all the dependents listed in your household. Example of supporting document – your most recent income tax filing, and comment on any difference between the tax filing list and now.

Contact the Financial Services Office 773-989-3841, if you need help in understanding what you need to do.

When you have supplied the information about your income and family size, we will begin to review your application, and we may ask for additional documents to help us determine if you can apply for other Illinois or Federal assistance programs. If you do not hear from us within 14 days following your submission, feel free to call the Financial Services Office 773-989-3841 to find out the status of your application.

******ALL INFORMATION PROVIDED IS KEPT CONFIDENTIAL******

Financial Services Representative:
Contact Phone Number:
Contact Hours:

FINANCIAL APPLICATION

Date of Application:_____

Patient Name:_____

Account Number (s): _____

Total Patient Responsibility:_____

Information Due Date:_____

Patient Statement

Name of person completing form if other than patient_____
(Note: completing does not mean that you will be responsible for the patient's hospital bill.)
Family size including patient (husband, wife, dependent children) _____

Name	Relationship to applicant	Age of dependent
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comment:_____
_____

1. Provide current earnings and income (wkly, bi-wkly, monthly, annual)
   Patient_____ _____
   Spouse_____ _____
   Other_____ _____

Comment:_____
_____

I certify that all information provided by me is complete and accurate to the best of my knowledge.

Signature:_____Date_____

West Suburban Medical Center

3 Erie Court | Oak Park, IL | 60302 | (708) 383-6200
www.westsuburbanmc.com

- Has Financial Assistance Instructions and Application link (pdf)
- Has link for "Pay Your Bill" from home page.
- Online financial assistance text:

Our Financial Assistance Policy

West Suburban Medical Center has a variety of financial assistance and charity care options for eligible community members. If you have any questions regarding your eligibility for the West Suburban Medical Center financial assistance and charity care, the Illinois Uninsured Patient Discount Act or any other insurance, billing or payment issue, please call our financial counselors toll-free at 888-770-4167 or at 708-938-4580.

Do you qualify for Financial Assistance?

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Instructions:
As part of its commitment to serve the community, _____ Hospital elects to provide financial assistance to individuals who are financially indigent or medically indigent and satisfy certain requirements.

To determine if a person qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please provide the information requested and mail to the following address:

_____ Hospital
_____
_____
_____

***Income Verification*:**

IN ORDER TO CONSIDER YOUR REQUEST FOR FINANCIAL ASSISTANCE, VERIFICATION OF INCOME IS REQUIRED. PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS:

- Governmental Assistance, Social Security, Workers Compensation, or Unemployment Compensation Determination Letter
- Income Tax Return for previous year

PLEASE ALSO INCLUDE ONE OR MORE OF THE FOLLOWING:

- IRS Form W-2, Wage and Earnings Statement for all household earnings
- Last 2 pay check stubs for all household earnings
- Bank Statement that contains income information

In the event income verification is unavailable, please contact our office for further instructions. Applications without verification are considered incomplete and **WILL NOT BE PROCESSED**. Please return the application and verification of income within 7 days to the above address.

Notification of Determination:
We will notify you of your eligibility following receipt and review of all necessary information. The notification will be mailed to the mailing address you have provided on the Financial Assistance Application.

Physician Services:
The physicians providing services at this Hospital are not employees of _____ Hospital. You will receive separate bills from your private physician and from other physicians whose services you required (pathologist, radiologist, surgeon, etc.). The Financial Assistance Application does not apply to any amounts due by you for physician services. For questions regarding their bills, or to make payment arrangements for physician services, please contact the individual physician's office.

For assistance in completing this application, please contact _____ Hospital [Customer Service] at (___) _____ or Toll Free: 1-_____, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

GRNTOR #: _____

HOSP CODE: _____

PATIENT INFORMATION/INFORMACION DEL PACIENTE

Patient Name/Nombre del Paciente	Account Balance/Balancia de Cuenta	Patient Number/Numero del Paciente	Date of Birth/Fetch del Nacimiento
Admission Date/Fecha De Entrada	Discharge Date/Fecha De Despedida	Social Security No/Num de Seguro Social	Marital Status/Estado Civil
Home Address/Direccion De Residencia			
City/Ciudad		State/Estado	Zip
Name of Medical Provider/Nombre Del Proveedor De Sercisios Medicos		Beginning Coverage Date/Fecha del Comienzo	
Name of Doctor/Nombre Del Medico			
Employer Name/Nombre		Occupation/Ocupacion	Telephone/Telefono

GUARANTOR INFORMATION/PERSONA RESPONSABLE

Name/Nombre		Social Security No/Num de Seguro Social	Age/Edad
Realationship to Applicant Relacion con el Paciente	Address/Direccion		Telephone/Telefono
City/Ciudad		State/Estado	Zip
Employer/Empleador		Employer Phone/Number De Empleador	Occupation/Ocupacion
Address/Direccion			
City/Ciudad		State/Estado	ZIP:

FINANCIAL INFORMATION/INFORMACION FINANCIAL

Total Monthly Income/Ingresos Mensuales	No. of Dependents Cuantos Dependientes	Residence(Own/Rent) Casa Propia o Renta	Car (Model/Year)/Carro (Modelo/Ano)

RESOURCES/RECURSOS

Name of Bank/Nombre del Banco	Checking Account/Cueta de Cheques	Savings Account/Cuentas de Ahorros
	$	$

MONTHLY EXPENSES/GASTOS MENSUALES

Rent/Mortgage/ Payment Payment/Renta o Pago Hipotecario	Water Bill/Pago de Agua	Gas Bill/Pago de Gas	Phone Bill/Cuenta De Telefono
$	$	$	$
Electric Bill/Pago de Electricidad	Car Payment/Pago de Carro	Insurance Premium/Pago de Prima	Other Bills/Otro Gastos
$	$	$	$

HOUSEHOLD COMPOSITION/INFORMACION DE LA CASA

Name/Nombre	Relationship/Relacion con el Paciente	Date of Birth/Fecha de Nacimiento	Social Security No. Num de Seguro Social

If unable to provide requested documents, please explain below/

Por favor de dar una explicacion si no es posible proveer los documentos.

COMMENTS/COMETARIOS:

AFFIDAVIT/DECLARACION JURADA

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge. I agree to tell the provider of service within ten (10) days if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses or in the persons household or any change of address. I understand that I may be asked to prove my statements and my eligibility statements will be subject to verification by contact with my employer, bank credit verification and property searches. I understand the county is required by law to keep any information I provide confidential. I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county from the proceeds of litigation or settlement resulting from such an act.	Declaro bajo pena de perjuria que las respuestas que he dado son verdaderas y correctas al mejor de mi conocimiento. Acuerdo decirle al abastecedor del servicio en el plazo de diez dias si hay algunos cambios en mi (o personas en el favor que yo este actuando) renta, propiedad, gastos o en la casa de las personas o cualquier cambio de direccion. Entiendo que puedo ser pedido probar mis declaraciones de la elegibilidad estaran conforme a la verificacion al lado de contacto con mi patron, verification del credito de banco y busquedas de propiedad. Entiendo que el condado es requerido por ley de protejer cualquier informacion que yo proporcione confidencial. Tambien convengo, en la consideracion de recibir servicios del cuidado medico como resultado de un accidente o lesion, de tener que reembolsarle al condado de los ingresos de la demanda o cualquier resultado de tal acto.

_____ _____

Signature/Firma Date/Fecha

For Hospital Use Only/Uso Solamente Para el Hospital

Facility/Facilidad: _____ **Accepted/Aceptar: _____** **Denied/Negacion: _____**

COMMENTS/COMETARIOS:

_____ _____

Signature Approval **Date**

GENERAL APPEAL

(SEND VIA CERTIFIED MAIL)

Patient Name and Address

Date

Insurance company address

Re: Patient/debtor name
Type of Coverage
Group number/Policy Number: # [123456]

To Whom It May Concern:

Please accept this letter as my appeal to **[insurance company name]** regarding **[a coverage denial, improper adjudication of medical claims, etc]** for the following medical claims:

1) Example claim number, date of service, submitted charges, name of provider
2) Example claim number, date of service, submitted charges, name of provider
3) Example claim number, date of service, submitted charges, name of provider

If you are appealing a coverage denial:
[Cite the reasons your insurance company listed in its Explanation of Benefits letters to deny payment and explain why this is incorrect. Quote the specific reason for the denial stated in denial letter. Enclose a copy of a letter from your doctor as support, if applicable].

If you are appealing an improper adjudication of medical claims:
[Cite the errors made by the insurer (such as: incorrectly applying a deductible or co-insurance) and refer your health plan's policy to prove your point. Quote the policy directly, if applicable].

Thank you for your assistance in this very important matter.

Sincerely,

Patient Signature
Print Name

Enclosures: **[list any enclosed documents]**
CC: **[Your state Attorney General]]**
[Your state Insurance Commissioner]

SAMPLE LETTER → ***INSURANCE COMPANY***

DENIAL BASED ON MEDICAL NECESSITY APPEAL

Patient Name/Address

Date

Insurance company address

Re: Patient: [patient name]
Policy: [insurance policy number]
Insured: [name of patient or insured person]
Treatment date(s): [admission date] - [discharge date]
Amount: [total charges]
Account #(s): **[123456]**

To Whom It May Concern:

You recently denied a claim on the grounds that the care provided by **[name of provider]** on **[date of services]** was not medically necessary. Denial of this claim was not justified and I would like to **appeal this decision**. This letter contains my appeal.

The explanation of benefits form that I received in the mail did not provide adequate information to establish the validity of this decision. Therefore, please provide the following information to support the denial of this treatment:

1) The name and credentials of the insurance representative who reviewed my medical claims.
2) An outline of the specific claims that were reviewed and a description of any additional records or information that would be necessary to approve the treatment.
3) Copies of any expert medical opinions that have been secured by your company regarding this treatment so that my physician can determine whether or not the decision was justified given my medical condition.

[Explain why this procedure was necessary for your medical care. Also list the previous communication you have had with the insurance company regarding this matter, including dates and name of person with whom you spoke].

If you can obtain a letter of support from your physician:
I believe that you did not have all the necessary information at the time of your initial review. Enclosed with this appeal is a letter from Doctor [your doctor's name] from [name of medical institution]. Dr. **[your doctor's name]** is a specialist in **[name of specialty]**. **[His/Her]** letter explains the medical procedure in more detail and describes why this care was medically necessary to treat my medical condition. **[If applicable: Also enclosed are my medical records and several journal articles explaining this procedure and the results]**.

Please review this claim again. If you need further information or a medical report, please inform me within 10 days. I can be reached at the following telephone number(s):
Daytime: [your phone number]
Evening: [your phone number] Thank you for your prompt attention to this very important matter.

Sincerely,

Patient Signature
Print Name

Enclosures: [list any enclosed documents]

CC: [list names and addresses of other recipients]
[Your state Attorney General]
[Your state office that does External Review]

SECOND-LEVEL APPEAL

(SEND VIA CERTIFIED MAIL)

Patient Name and Address

Date

Attn: Director of Claims
Insurance company address

Re: Patient: [patient name]
Policy: [insurance policy number]
Insured: [name of insured person]
Treatment dates: [admission date] - [discharge date]
Amount: [total charges]

To Whom It May Concern,

On **[date of first letter]**, I appealed the following denied insurance claims:

1) Example claim number, date of service, submitted charges, name of provider
2) Example claim number, date of service, submitted charges, name of provider
3) Example claim number, date of service, submitted charges, name of provider

A copy of my first appeal is enclosed with this letter.

I am writing this letter because I **[have not yet heard from you, the claim remains denied, or give other reason here]**. I would like to request a hearing to resolve this matter. I feel that denial and nonpayment of this claim has jeopardized my access to health care **[or give other reason here]**.

If I do not hear from you within ten days, I am referring this matter to the Illinois Attorney General's Health Care Bureau, the Illinois Department of Insurance Consumer Services Section, and may also seek private legal counsel.

In my opinion, you have failed in your obligation to provide acceptable and adequate service. Be assured that I intend to use every available means to get this matter resolved.

Thank you for your assistance in this very important matter.

Sincerely,

Patient Signature
Print Name

Enclosures: **[list any enclosed documents]**
CC: **[list names and addresses of other recipients]**
[Your state Attorney General]
[Your state agency that does external review]

SAMPLE LETTER → ***MEDICAL PROVIDER***

REQUEST FOR FINANCIAL ASSISTANCE

Patient Name and Address

Date

Medical Provider Address

Re: patient/debtor name, Account # **[123456]**

Dear **[name of Chief Financial Officer]**,

I am the patient on the above referenced account and am contacting your hospital regarding my bill(s) amounting to **[$ amount of medical bill]**. I received medical care from your institution **[list date(s) of service or range of dates when you received medical services]**.

I greatly appreciate the care that I received but I cannot afford the bills for these services. **[Explain in a few sentences why your family economic situation makes it impossible for you to pay these bills. Include information about your insurance status, if appropriate].**

[Example #1 - I believe that I may be eligible for assistance given my family income. I just recently learned about your financial assistance policy and spoke with staff members from your institution. They have asked me to document my financial situation and I (have done so OR am in the process of doing so). I hope that you will approve my request for assistance.]

[Example #2 – I believe that I may be eligible for assistance given the size of my medical bills and my family income. I just recently learned about your financial hardship policy and spoke with staff members from your institution. They have asked me to document my financial situation and I (have done so OR am in the process of doing so). I hope that you will approve my request for hardship assistance]

Thank you for your assistance in this very important matter. I greatly appreciate your kindness and generosity in this difficult time.

Sincerely,

Patient Signature
Print Name

CC:
[Your state Attorney General]

HOSPITAL VIOLATION OF AMERICAN HOSPITAL ASSOCIATION GUIDELINES

(You can access the American Hospital Association (AHA) guidelines at: http://www.aha.org/aha/content/2004/pdf/guidelinesfinalweb.pdf)

Patient Name and Address

Date

Hospital address

Re: patient/debtor name, Account # **[123456]**

Dear **[name of hospital Chief Financial Officer]**,

I am the patient on the above referenced account and am contacting your hospital regarding my bill(s) amounting to **[$ amount of medical bill]**. I received medical care from your institution **[list date(s) of service or range of dates when you received medical services]**.

I appreciate the care that I received and would like to pay a fair and reasonable price for these services. Unfortunately, my health insurance left me with a significant out-of-pocket burden and I am unable to afford the entirety of my medical bills. **[Explain in a few sentences why your family economic situation makes it impossible for you to pay these bills].**

I believe that I may be eligible for Charity Care given my family's income level. However, I never received a copy of your institution's charity care policy even though I asked for this information on numerous occasions **[list dates when you asked for this information and names of people that you spoke with]**.

[If the hospital signed the American Hospital Association Guidelines:] The American Hospital Association (AHA) website listed your hospital as having confirmed commitment to its Guidelines for Billing and Collections Practice. Given my experience working with your institution's billing office. However, I believe that your hospital has not abided by the AHA Guidelines. **[List the provisions in the guidelines that their practices have violated]**.

Thank you for your assistance in this very important matter.

Sincerely,

Patient Signature
Print Name

Enclosures: **[list any enclosed documents]**
CC: **[Your state Attorney General]**

SAMPLE LETTER → ***MEDICAL PROVIDER***

CONFIRMATION OF SETTLEMENT OR PAYMENT PLAN, NO COLLECTIONS

Patient Name and Address

Date

Medical Provider Name
Medical Provider Address

RE: Patient's name, Account # **[123456789]**

To Whom It May Concern,

I am writing to confirm the **(settlement/payment plan/charity care/bill forgiveness/etc)** that **[insert name and title of individual]** agreed to in a telephone conversation on **[insert date].**

My account is with **[insert provider names].** The provider billed me **[insert $ amount]** for medical services that I received on **[insert dates]**.
OR
I have been billed for the following accounts:
[List names of providers, dates of service, and amounts]

[Insert name] and I agreed to settle my account with **[name provider]** for **[insert amount]**.
AND/OR
[Insert name] and I agreed on a payment plan for [insert amount] per month until the bills are completely paid.
AND/OR
[Insert name] offered a discount of **[insert discount amount]**. I accept this discount and will pay the remaining amount of the bill (**through a pay plan, list amount per month, or, in full and my check is enclosed with this letter).**

(If you get a payment plan):
Please send me monthly statements that list the amount I pay each month and my remaining account balance. Please write to confirm the payment arrangement that **[insert name and title of individual]** and I agreed upon on **[insert date].**

I was told by **[insert name]** in our telephone conversation on **[insert date]** that this bill will not be sent to collections and that it will not appear on my credit report. Please write to confirm that this bill will not be sent to collections, neither now nor at any future date, and that it will never appear on my credit report.

Thank you very much for working with me to resolve these medical bills.

Sincerely,

Signature of Patient
Printed Name

Enclosures: **[list enclosures with the letter: copies of bills, income verification, etc.]**
CC: [Your State Attorney General]

SAMPLE LETTER → ***COLLECTION AGENCY OR MEDICAL PROVIDER***

CONFIRMATION OF SETTLEMENT/PAYMENT PLAN IF IN COLLECTION

Patient Name and Address

Date

Collection Agency or Medical Provider Name
Address

RE: Patient's name, Account # **[123456789]**

To Whom It May Concern,

I am writing to confirm the **(settlement/payment plan/charity care/bill forgiveness/etc)** that **[insert name and title of individual]** agreed to in a telephone conversation on **[insert date].**

My account is with **[insert provider names].** The provider billed me **[insert $ amount]** for medical services that I received on **[insert dates]**.
OR
I have been billed for the following accounts: **[List names of providers, dates of service, and amounts]. [Insert name]** and I agreed to settle my account with **[name provider]** for **[insert amount]**.
AND/OR
[Insert name] and I agreed on a payment plan for [**insert amount**] per month until the bills are completely paid.
AND/OR
[Insert name] offered a discount of **[insert discount amount]**. I accept this discount and will pay the remaining amount of the bill (**through a pay plan, list amount per month, or, in full and my check is enclosed with this letter).**

(If you get a payment plan):
Please send me monthly statements that list the amount I pay each month and my remaining account balance. Please write to confirm the payment arrangement that **[insert name and title of individual]** and I agreed upon on **[insert date].**

(If you get an agreement to delete once paid):
I was told by **[insert name]** in our telephone conversation on **[insert date]** that since I was not aware of financial assistance at the time of my treatment, once this bill has been fully paid or settled it will be removed from my credit report. I am writing to confirm that this bill will be removed from my report after I have paid the remaining balance.

Thank you very much for working with me to resolve these medical bills.

Sincerely,

Signature of Patient
Printed Name

Enclosures: **[list enclosures with the letter: copies of bills, income verification, etc.]**
CC: [Your State Attorney General

CEASE COMMUNICATION

(SEND VIA CERTIFIED MAIL)

Patient Name and Address

Date

Collections Agency Name and Address

Re: patient/debtor name, Account #(s) **[ex: 123456, 789101112, 13141516, etc.]**

To whom it may concern,

I am the patient on the above referenced account(s) and am contacting your agency regarding the bill(s) amounting to **[$ amount of bill(s) from collection agency]**.

I am writing this letter to request that you immediately cease telephone communications with me regarding this account. Continuous phone calls are serving no purpose except to harass me.

You can correspond with me via U.S. mail. My address is printed above. Any future phone calls I receive at my home or at my work will be reported to the Federal Trade Commission as a violation of my rights according to 15 U.SC. 1692c.

This letter is not meant in any way to be an acknowledgment that I owe this money. Your cooperation will be appreciated.

Sincerely,

Patient signature
Print name

CC: **[Your state Attorney General]**

SAMPLE LETTER → ***COLLECTION AGENCY***

MEDICAL DEBT VALIDATION (SEND VIA CERTIFIED MAIL)

Patient Name and Address

Date

Collection Agency Name and Address

Re: patient/debtor name, Account #(s) **[ex: 123456, 789101112, 13141516, etc.]**

To whom it may concern,

This letter is being sent to you in response to an entry made on my **[name of Credit Reporting Agency, e.g. Experian, TransUnion, or Equifax]** credit report, dated **[date that credit report was pulled]**. Please be advised that this is not a refusal to pay, but a notice sent pursuant to the Fair Debt Collection Practices Act, 1:USC 1692g Sec 809 (b) that I dispute this claim and request validation.

Under the Fair Debt Collections Practices Act, I have the right to request validation of the debt you say that I owe you. I am requesting proof that 1) I am indeed the party you are asking to pay this debt, and 2) there is some contractual obligation which is binding on me to pay this debt. This is NOT a request for "verification" or proof of my mailing address, but a request for VALIDATION made pursuant to the above named Title and Section of the Fair Debt Collections Practices Act.

You should also be aware that reporting inaccurate and unsubstantial information to a credit reporting agency might constitute fraud under federal law. Your legal staff will agree that compliance with this request is required under state and federal statutes.

In addition to the debt validation form, please attach copies of:

1. Agreement with your client that grants you the authority to collect on this alleged debt, or proof of acquisition by assignment.
2. Agreement that bears the signature of the alleged debtor wherein he or she agreed to pay the creditor.

Please provide this information in writing via U.S. Mail to my address listed above. I require compliance with the terms and conditions of this letter within 30 days or a complete withdrawal, in writing, of any claim. In the event of noncompliance, I reserve the right to file charges and/or complaints with appropriate county, state and federal authorities. I also hereby reserve my right to take private civil action against you to recover damages.

In addition, the Fair Credit Reporting Act states that while this item is being investigated, you must remove this item from my credit report and cease all collection actions until full validation has been completed. I have taken the liberty of sending a copy of this letter to the Credit Reporting Agencies.

I understand that my request is consistent with the Code of Ethics and Code of Operations of the Association of Credit and Collection Professionals (ACA), Rule II sections A and B, as well as the Fair Debt Collections Practices Act. I am aware that your agency is a member of ACA **[You can look this up on the ACA website, www.acainternaitonal.org].**

This letter is not meant in any way to be an acknowledgment that this debt is mine or that I owe this money. Your cooperation will be appreciated regarding this important matter.

Sincerely,

Patient signature
Print name

SAMPLE LETTER → ***CREDIT BUREAU***

VERIFICATION AND DISPUTE OF DEBT

Patient Name and Address

Date

Credit Bureau Name and Address

To whom it may concern,

I am writing to verify and dispute the following information in my file. I have circled the items that I dispute on the enclosed copy of my credit report.

1) Example account number (subscriber #: example number)
2) Example account number (subscriber #: example number)
3) Example account number (subscriber #: example number)

Each of these accounts arose from medical care that I supposedly received. These items are **[inaccurate or incomplete]** because **[describe what is inaccurate or incomplete and why]**. I am requesting that the items be removed **[or request another specific change]** to correct the information.

For verification purposes, I would like to following information about these items: 1) the name of the original creditors, 2) the amount of the original medical bills, 3) any information you may have about the services provided, and 4) the dates on which the bills were incurred. Please notify me in writing if you are unable to provide a verification of these debts.

Enclosed is a copy of my credit report with circles around the disputed items as well as copies of **[describe any additional enclosed documentation, such as payment records, court documents]** supporting my position Please reinvestigate these matters and **[delete or correct]** the disputed items as soon as possible. Please notify me in writing when a decision has been made with regards to my dispute.

[Add a sentence about any financial problems that you are facing because your credit is damaged by medical bills, such as inability to refinance your home, get a credit card, get a car loan, etc].

This letter is not meant in any way to be an acknowledgment that this debt is mine or that I owe this money. Your cooperation will be appreciated regarding this important matter.

Sincerely,

Patient signature
Print name

Enclosures:
[Credit Report with disputed items highlighted]
[Proof of address (a utility bill, for example)]
[Any additional documentation]

CC: **Your State Attorney General**

SAMPLE LETTER → ***CREDIT BUREAU***

VERIFICATION AND DISPUTE OF DEBT

Patient Name and Address

Date

Credit Bureau Name and Address

To whom it may concern,

I am writing to verify and dispute the following information in my file. I have circled the items that I dispute on the enclosed copy of my credit report.

1) Example account number (subscriber #: example number)
2) Example account number (subscriber #: example number)
3) Example account number (subscriber #: example number)

Each of these accounts arose from medical care that I supposedly received. These items are **[inaccurate or incomplete]** because **[describe what is inaccurate or incomplete and why]**. I am requesting that the items be removed **[or request another specific change]** to correct the information.

For verification purposes, I would like to following information about these items: 1) the name of the original creditors, 2) the amount of the original medical bills, 3) any information you may have about the services provided, and 4) the dates on which the bills were incurred. Please notify me in writing if you are unable to provide a verification of these debts.

Enclosed is a copy of my credit report with circles around the disputed items as well as copies of **[describe any additional enclosed documentation, such as payment records, court documents]** supporting my position Please reinvestigate these matters and **[delete or correct]** the disputed items as soon as possible. Please notify me in writing when a decision has been made with regards to my dispute.

[Add a sentence about any financial problems that you are facing because your credit is damaged by medical bills, such as inability to refinance your home, get a credit card, get a car loan, etc].

This letter is not meant in any way to be an acknowledgment that this debt is mine or that I owe this money. Your cooperation will be appreciated regarding this important matter.

Sincerely,

Patient signature
Print name

Enclosures:
[Credit Report with disputed items highlighted]
[Proof of address (a utility bill, for example)]
[Any additional documentation]

CC: **Your State Attorney General**

INCORRECT PERSONAL INFORMATION

Patient Name and Address

Date

Credit Bureau Name and Address

To whom it may concern,

I am writing because my credit report lists the following accounts as mine—this is incorrect. I have circled the disputed items on an enclosed copy of my credit report.

1) Example account number (subscriber #: example number)
2) Example account number (subscriber #: example number)
3) Example account number (subscriber #: example number)

These accounts belong to someone else and the information that appears is incorrect. My social security number is: _____, and my current address is noted above. The correct spelling of my full name is: _____. Please remove these erroneous accounts and update my credit report to accurately reflect my credit history:

Please send me an updated copy of my file as soon as you have completed an investigation into this matter.

[Add a sentence about any financial problems that you are facing because your credit is damaged by medical bills, such as inability to refinance your home, get a credit card, get a car loan, etc].

This letter is not meant in any way to be an acknowledgment that this debt is mine or that I owe this money. Your cooperation will be appreciated regarding this important matter.

Sincerely,

Your signature
Print name

Enclosures:
[Credit Report with disputed items highlighted]
[Proof of address (a utility bill, for example)]
[Any additional documentation]

CC: **Your State Attorney General**

SAMPLE LETTER → ***CREDIT BUREAU***

CONSUMER STATEMENT

Patient Name and Address

Date

Credit Bureau Name and Address

To whom it may concern,

I am writing to request that this consumer statement be added as part of my credit bureau file, so that any credit inquiries will include this statement automatically:

Example 1: As a result of [illness, injury, etc.] I accumulated medical bills that I couldn't afford. I owed [insert amount of medical debt] to [insert number of medical providers], which was impossible to pay on my income of [insert yearly or monthly income]. I was [uninsured or underinsured] when I got sick. Since that time, I have [returned to work, improved my financial situation, gotten another job, etc.] and have improved my credit history.

Example 2: As a result of (illness, injury) I have medical bills. At the time of my medical treatment, I was (uninsured or inadequately insured) and had limited financial resources but was not informed of existing financial assistance policies. Given that I (have since qualified for, or believe that I should quality for) financial assistance, I feel that it is inappropriate for these medical accounts to appear on my credit report.

Because this statement contains less than 100 words, I request that my full statement be included without alteration. Please send me a copy of my updated credit report as soon as the above has been completed.

This letter is not meant in any way to acknowledge that these debts are mine or that I owe this money. Your cooperation will be appreciated.

Sincerely,

Your signature
Print name

Enclosures:
[Proof of address (a utility bill, for example)]
[Any additional documentation]

CC: **Your State Attorney General**

Note:
Your consumer statement MUST be 100 words or less.
Write one letter to each of the three credit bureaus: Experian, TransUnion, Equifax.