Mat Su Regional Medical Center

Subject:
UNINSURED/SELF PAY DISCOUNT POLICY

Originally Issued 8-23-14
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POLICY STATEMENT

In order to serve the health care needs of our community, **Mat Su Regional Medical Center** will provide discount care to uninsured patients, who do not otherwise qualify for third party coverage, local, state and/or government assistance with their health care bills.

Discount care will be provided to all patients without regard to race, creed, color, religious beliefs or national origin, and regardless of whether they qualify for financial assistance.

PURPOSE:

To properly identify those patients who do not have insurance and do not qualify for third party coverage, state and/or government assistance, and to provide assistance with their medical expenses under the guidelines for the Uninsured/Self Pay Discount Policy.

ELIGIBILITY FOR DISCOUNT CARE

1. To be eligible for a reduction in the patient balance through the Discount Policy, the patient must be uninsured and the hospital services are not covered in whole or part, by any other third party source.

2. The services provided must be on or after original issue date of this policy.

3. Patients who do not apply for financial assistance and/or do not provide the documents required to make a determination with respect to financial assistance will be eligible for a discount under this policy.

4. The services the patient receives must be emergency services or medically necessary based on Medicare Medical Necessity criteria.

THE AMOUNT OF THE DISCOUNT PROVIDED

All patients are eligible for a discount of off billed charges.

EXCLUDED FROM COVERAGE

1. Patients covered by any insurance, local, state or government health care coverage or other third party coverage. This includes any portion of a hospital bill where the patient's insurance has denied or excluded certain services from coverage.

2. Patients who qualify for and receive financial assistance from the hospital. However, any patient eligible for financial assistance, whether or not covered in whole or in part by insurance or other coverage, may not be billed more than the applicable AGB percentage of the hospital's gross charges.

3. Patient's requesting cosmetic procedures or other non-emergency services not considered medically necessary based on Medicare medical necessity criteria. In the case of elective procedures such as cosmetic procedures or weight reduction procedures, package pricing often applies and a discount is automatically provided within the package pricing. These services should not be provided until the patient has paid for the service in advance.

4. Any other patient/account already receiving a discount, such as (but not limited to) Industrial Accounts or Client Accounts.

THE PROCESS

1. Identification of Patients Eligible for Discount Policy:

A. All patients with no insurance who do not qualify for financial assistance or who do not apply for financial assistance will be eligible for a discount off billed charges under this policy.

B. During the screening process for financial assistance and the Discount Programs, the financial counselor or self-pay screening vendor will screen for potential Medicaid eligibility as well as coverage by other sources, including governmental programs. During this screening process a "FA" will be completed. (Exhibit A) While it is not necessary that a FA be completed in order to receive a discount, when a FA is completed during the screening process, it will be used for the purpose of this policy as well.

C. All uninsured patients will be screened for existing Medicaid coverage by using the hospital's insurance eligibility software. A copy of the response will be retained as verification that the patient did not have Medicaid coverage.

D. The hospital will view prior accounts for the patient as well as the guarantor to determine if insurance coverage existed on prior hospital records. If so, the hospital will 'verify insurance coverage' and document the call and response.

E. The hospital reserves the right to pull a copy of the patient's credit report for verification of information provided.

F. When it is determined the patient does not qualify for Medicare, Medicaid or any other third party coverage and the patient does not qualify for Charity Care, the patient will immediately qualify for a discount off billed charges. Information to make a determination of coverage and who do not provide the necessary information to make a Financial Assistance determination will be eligible for a discount off billed charges.

2. FAILURE TO PROVIDE ACCURATE INFORMATION

If it is later determined that the patient qualified for coverage by Medicare, Medicaid or any other third party coverage or met the criteria for the hospital Financial Assistance program, any discount provided for under this policy shall be reversed.

3. DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF

A. For those patients screened by the hospital financial counselor or self-pay screening vendor, once the eligibility determination has been made, the results will be documented in the comments section on the patient's account

B. The discount will be set in the system and will not require hospital authorization.

C. Transaction codes used will reflect 'Self Pay Discount' and will not be considered financial assistance

D. The hospital will use transaction the appropriate code **for** Inpatient discounts, and **for** outpatient discounts (HMS hospitals).

4. REPORTING OF DISCOUNT CARE

Information regarding the amount of discount care provided by the hospital, based on the hospital's fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits. (Only for those states that require).

Exhibit A
Financial Assistance Program Application

Mat Su Regional Medical Center

Patient Account numbe _____ Date of Application _____

PATIENT INFORMATION		PARENT/GUARDIAN/SPOUSE	
Name	_____	Name	_____
Address	_____	Address	_____
City	_____	City	_____
State / Zip	_____	State / Zip	_____
Employer	_____	Employer	_____
Address	_____	Address	_____
City	_____	City	_____
State/ Zip	_____	State/ Zip	_____
Work Phone	_____	Work Phone	_____
Length of Employment	_____	Length of Employment	_____
Supervisor	_____	Supervisor	_____

RESOURCES

Checking	__ yes ___no	Vehicle 1:	Year:____	Make:____	Model:_____
Savings	__ yes ___no	Vehicle 2:	Year:____	Make:____	Model:_____
Cash on hand:	$ _____	Vehicle 3:	Year:____	Make:____	Model:_____

Exhibit A (continued)
Financial Assistance Program Application

INCOME

Patient/ Guarantor Wages (monthly)	$ _____	Spouse/ 2nd parent Wages (monthly)	$ _____
Other Income		Other Income	
Child support:	$ _____	Child support:	$ _____
VA Benefits:	$ _____	VA Benefits:	$ _____
Worker's Comp:	$ _____	Worker's Comp:	$ _____
SSI:	$ _____	SSI:	$ _____
Other:	$ _____	Other:	$ _____

LIVING ARRANGEMENTS

Rent _____ Own: _____ Other: _____

Landlord / Mortgage Holder: _____

Phone number _____ Monthly Payments $ _____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Financial Assistance:

- **Proof of Income:** Prior year income tax return, last 4 pay check stubs, letter from employer, Social Security, etc. Last 3 months bank statements. Other documents as requested.
- **Proof of Expenses:** Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of applicant _____

Hospital Representative Completing Application: _____

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Approval/ Authorization of Financial Assistance Write-Off Amount Approved: $ _____

BOM: _____

CFO: _____

CEO: _____

Mat-Su Regional Medical Center

Форма заявления на предоставление финансовой помощи
Региональный медицинский центр Mat-Su
Заявление на участие в Программе благотворительной поддержки/финансовой помощи

Учетный номер пациента: _____ Дата обращения: _____

ИНФОРМАЦИЯ О ПАЦИЕНТЕ

Имя и фамилия _____
Адрес _____
Город _____
Штат/индекс _____
Номер социального обеспечения _____
Работодатель _____
Адрес _____
Город _____
Штат/индекс _____
Служебный телефон _____
Стаж работы _____
Руководитель _____

РОДИТЕЛЬ/ПОРУЧИТЕЛЬ/СУПРУГ(А)

Имя и фамилия _____
Адрес _____
Город _____
Штат/индекс _____
Номер социального обеспечения _____
Работодатель _____
Адрес _____
Город _____
Штат/индекс _____
Служебный телефон _____
Стаж работы _____
Руководитель _____

Ресурсы

Чековый счет: да ___ Автомобили 1 Год _____ Марка _____ Модель_____
Сберегательный счет: да ___ Автомобили 1 Год _____ Марка _____ Модель_____
Автомобили 1 Год _____ Марка _____ Модель_____

Наличные средства $_____

Mat-Su Regional Medical Center

Региональный медицинский центр Mat-Su
Заявление на участие в Программе благотворительной поддержки/финансовой помощи

ДОХОД

Пациент/поручитель
Заработная плата (в месяц): _____

Иной доход: Алименты $ _____

Пособие ветеранам: $ _____

Компенсация за вред, причиненный здоровью работника: $_____

Дополнительная социальная помощь (SSI): $ _____

Другое: $ _____

Супруг(а)/второй родитель:
Заработная плата (в месяц):_____

Иной доход: Алименты $ _____

Пособие ветеранам: $ _____

Компенсация за вред, причиненный здоровью работника: $ _____

Дополнительная социальная помощь (SSI): $ _____

Другое: $ _____

ЖИЛЬЕ

Аренда _____ Собственное _____ Другое (поясните) _____
Арендодатель/залогодержатель: _____
Номер телефона _____ Ежемесячная плата $ _____

НЕОБХОДИМЫЕ ДОКУМЕНТЫ

К вашему заявлению на получение благотворительной поддержки/финансовой помощи необходимо приложить следующие документы:

Подтверждение дохода: декларация по подоходному налогу за прошлый год, корешки последних 4 чеков на выплату заработной платы, письмо от работодателя, органа социального обеспечения и т. д., выписки по банковскому счету за последние 3 месяца. Другие документы по требованию.

Подтверждение расходов: копия договора залога или аренды, копии всех ежемесячных счетов (включая кредитные карты, банковские займы, займы на приобретение автомобиля, страховые платежи, счета за коммунальные услуги, стационарный и мобильный телефон). Другие документы по требованию.

Информация, изложенная в настоящем заявлении, подлежит проверке сотрудниками больницы и была предоставлена с целью определить мою способность погасить задолженность. Я понимаю, что в случае указания мною неверной информации больница откажет мне в предоставлении какой-либо финансовой помощи.

Больница оставляет за собой право получить копию вашей кредитной истории.

Подпись заявителя _____

Сотрудник больницы, оформивший заявление: _____
Подписи указывают на то, что вы рассмотрели заявление и сопроводительную документацию и находите информацию соответствующей установленным правилам.
Одобрение/разрешение на предоставление благотворительной поддержки _____ Одобренная сумма $_____

Руководитель подразделения _____ Генеральный директор _____

Финансовый директор _____