



PATIENT FINANCIAL HARDSHIP APPLICATION
PLEASE MAIL BACK TO BILLING OFFICE AT
PO BOX 811
TOMS RIVER, NJ 08754

Patient Name – Balance \$ _____

Practice Name abides by the contractual and legal obligations of health benefit plans to collect all charges, co-pay, co-insurance, and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full, **Practice Name** has adopted a policy of screening requests for discounts, delayed payment plans, or forgiveness of debt based on individual circumstances. In order to do this, we must ask for certain financial information. Please complete the following form to the best of your ability and provide the following supporting documentation: **APPLICATION WILL NOT BE REVIEWED IF WE DO NOT RECEIVE ALL ITEMS REQUESTED AND/OR IF ANY INFORMATION IS OMITTED.**

- A copy of last year's tax return; (MUST BE SIGNED)
- Information from two recent payroll or unemployment benefit payments; for all persons employed in the home
- If income is close to or below poverty level, denial of state medical assistance
- Forms from employers or welfare agencies

All information will be held confidential as per **Practice Name** privacy policy.

Patient Name: _____ DOB: _____ SS#: _____
Spouse Name: _____ DOB: _____ SS#: _____
Guarantor name(s): _____ Dates of services: _____
Number of dependants per guarantor household: _____ Number in school: ____ Household total: ____
Phone: _____ E-mail: _____

Attached copy of Driver's License or identification card for all adults.

Type of Assistance Requested:

Reduced deductible _____ Reduced co-pay/co-insurance/Non covered _____
Discounted cash services _____ Payment plan _____

Employment/Unemployment Information (for each adult family member):

Employer name: _____
Address: _____
Phone: _____

If unemployed please state when employment terminated or if lay-off is temporary, indicate expected duration:

Assistance Received:

State financial assistance _____ WIC _____ Food Stamps _____ Charity Care/other _____

Property/Investment Values:

Home _____ Other real estate owned _____ Land _____
Business _____ Livestock _____
Savings/stocks/bonds _____ Other Investments _____

Please complete the information in the following table based on average income and expenses over the last twelve months. For amounts paid annually, enter annual amount divided by twelve. **Household Financial Information**

Monthly Income (after payroll deductions)		Monthly expenses (not including payroll deductions)	
Employment		Mortgage/rent	
Unemployment/severance		Auto/transportation	
Self-employment		Non-reimbursed work expenses (e.g., parking, tools)	
Interest/dividends		Insurances (e.g., life, homeowners)	
Pension/disability		Utilities (lights, water, gas, trash)	
Child support/alimony		Medications	
Short-term disability		Childcare	
Long-term disability		Credit cards	
Rental income		Child support/alimony	
Other income:		Personal property taxes (home, auto)	
		Other:	
Total average income		Total average expenses	

By my signature below, I certify that this information is true and complete. I grant -eNm permission to verify this information and acknowledge that completion of this form does not guarantee discount, payment plan, or forgiveness of debt.

Signed: _____ Date: _____

The 2009 Poverty Guidelines for the
48 Contiguous States and the District of Columbia

Persons in family	Poverty guideline
1	\$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010
For families with more than 8 persons, add \$3,740 for each additional person	

PLEASE DO NOT WRITE BELOW. FOR OFFICE USE ONLY

Received hardship letter from patient on: _____ (Letter attached)

Application Reviewed by: _____ Date: _____

Approved for: Discounted amount \$ _____ Forgiveness of debt \$ _____ Payment Plan. First Payment due on: _____

Monthly Payment \$ _____ Approved On: Date: _____ By: _____

Next review date: _____



Practice Name
Address
City, St Zip Code

Today's Date

Patient Name
Address
City, St, Zip

Re: Your Insurance carrier has informed us payment was made directly to member- Account #-

Dear Patient:

Our office policy requires that all balances be paid in full within thirty (30) days of treatment.

Please be advised your insurance company has notified us that they have paid you for services we provided to you. The total amount unpaid is \$ _____.

To date we have not received the funds due us nor have we heard from you to make payment arrangements.

Please pay the balance shown to avoid further collection action and/or having to proceed with prosecution to the full extent of law.

If you have already forwarded payment, thank you, however please call our office to inform us as to when we should expect it and disregard this letter, otherwise forward payment immediately to the address listed above.

Your failure to turn over this payment to us could be considered insurance fraud and a criminal offense.

Please contact our billing office at 732-244-2775 if you have any questions or concerns about your account.

Sincerely,
Billing Office



Practice Name
Address
City, St Zip Code

Today's Date

Patient Name
Address
City, St, Zip

Re: Pre-Existing Clause
Primary Carrier :
Secondary Carrier :

Dear Patient:

We recently submitted a claim on your behalf and it was denied. Per your insurance carrier your policy has a pre-existing clause that requires actions by you in order for your claims to be paid.

As a result of this "**pre-existing clause**" your claims have been denied and you may be fully responsible for payment. **Your current balance is: \$_____.**

Please note we cannot resubmit this denied claim. Please contact your insurance carrier for more information.

Please note that our office policy requires all balances to be paid within 30 days from date of service unless previous arrangements were made in advance.

If you have any questions, please contact our billing office at 732-244-2775 between the hours of 10:00 am and 4:00 pm Monday - Friday.

Thank you.

Billing Department

CC: Practice Name



Practice Name
Address
City, St Zip Code

Today's Date

Patient Name
Address
City, St, Zip

Re: Need Correct Insurance Information **Please verify insurance information below:**
If there is no Policy Number , please call billing office to provide missing information
Primary Carrier : _____ Secondary Carrier : _____

Dear Patient Acct #:

We currently submitted a claim on your behalf and it was denied. Above is the insurance information we have on file. Please verify the information. If blank, this indicates we have NO insurance information on file. **Your current balance is: \$ _____**

If you recently changed your insurance carrier or the information is not correct, please send us a copy of the front and back of your card. You may fax the information to 732-244-1005.

If we do not receive this information within 5 days, you will be responsible for the full amount due.

Please note that all balances must be paid within 30 days from date of services unless previous arrangements were made in advance. If you need to make payment arrangements, please contact our billing office.

If you have any questions, please contact our billing office at 732-244-2775 between the hours of 10:00 am and 4:00 pm Monday - Friday.

Thank you.

Billing Department

NCOALink REPORT SAMPLE

02/22/2010 13:55:19

NCOALink Report for Dailey Billing

NCOALink File Name daileybilling.TXT

Date: 02/22/2010

Time: 13:54:41

Type Code

Info Code

I - Individual

For explanation of

NCOALink

F - Family

Move codes, see

attached info

B - Business

At the bottom of

report

Old Address

Forwarding Address

4106

DAILEY BILLING

Jane Doe

Jane Doe

611 SPINE ST

15 Billing Lane

somewhere, NJ 07228

Elsewhere BEACH, NJ 08005-1015

Carrier Route: C003 Effective

Date: 01-2010

Type Code: F Info Code: A



Practice Name
Address
City, St Zip Code

Today's Date

Patient Name
Address
City, St, Zip

Re: Outstanding Balance Pt. Account

Dear Patient:

Our office has attempted several times to collect payment for services provided to the above mentioned patient. As of today's date, we have exhausted all efforts to collect the outstanding balance.

We ask that you please assist us recover monies that are owed. Together, we can resolve this delinquency as well as avoid unnecessary cost of sending this account to a collection agency or attorney.

Payment in full must be received in our office within 10 days. Please contact our billing office at 732-244-2775 if you are not able to pay the balance in full.

If you are interested in paying by Visa, Mastercard or Discover, simply complete the lower portion of this letter and return to our office . You may also pay by credit card, checking and/or savings account through our billing office website, www.daileybilling.com and clicking on "**Pay My Bill**".

Sincerely,

Billing Office

Dailey Billing Services, Inc.

CC: Providers

___ Visa ___ Mastercard ___ Discover : Card # _____ Exp.
Date: _____

Payment Amount: _____ Signature: _____ Pt. Account
~ _____

Remit to: ~eNm , ~eAdd, ~eCity,~eSt ~eZip

IF PAYMENT HAS BEEN MADE, ACCEPT OUR THANKS AND DISREGARD THIS NOTICE.