HOLLYWOOD PRESBYTERIAN MEDICAL CENTER

Manual: Patient Accounting Services	
Title: Charity Care/Discount Payment- Review and Evaluation Process	
Formulated: January 1, 2005	**Page 1 of 18**
Reviewed Only: (no changes)	**Revised: 1/13; 1/15; 8/17; 8/18; 06/22; 10/22; 6/23; 5/24**
Date Approved: May 30, 2024	

Purpose:

This policy is intended to:

- Define the forms of available Financial Assistance and the associated eligibility criteria.
- Establish the processes that patients shall follow in applying for Financial Assistance and the process Hollywood Presbyterian Medical Center (HPMC) will follow in reviewing applications for Financial Assistance; and
- Provide a means of review in the event of a dispute over a Financial Assistance determination.
- Provide administrative and accounting guidelines to assist with identifying, classifying and reporting Financial Assistance
- Establish guidelines and standards that HPMC will follow with respect to the collection of patient debt including patients who are eligible for Financial Assistance.

GENERAL INFORMATION

A. Scope of Policy. This policy is for services furnished by Hollywood Presbyterian Medical Center and does not create an obligation to pay for charges of physicians or other medical providers including anesthesiologists, radiologists, emergency department physicians, pathologists, etc., not included in the hospital bill.

Scope:

Patient Accounting

Admitting/Registration

Definition(s) and Eligibility:

Financial Assistance is available to eligible patients who receive Covered Services and who follow applicable procedures which include a completed Financial Assistance application and providing the required financial information.

1. Financial Assistance. The term Financial Assistance refers to Full and Partial Charity Care, Special Circumstances Charity Care, and High Medical Cost Charity Care.

2. Full Charity Care. Full Charity Care is a complete (100%) write-off of HPMC's undiscounted charges for Covered Services provided to the patient less any payments made by the patient. Full Charity Care is available to patients:

    a. Whose Family Incomes are at or below 200% of the most recent Federal Poverty Income Guidelines (Exhibit A); and

    b. Who have no source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs, or third-party liability.

3. Partial Charity Care. Partial Charity Care is a partial write-off of HPMC's undiscounted charges for Covered Services available to patients:

    a. Whose Family Incomes are between 201% and 3245% of the federal poverty level according to the most recent Federal Poverty Income Guidelines shall qualify for a discounted percentage of eighty percent (80%)(Exhibit A); and

    b. Who have no source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs, or third-party liability.

    c. For patients whose Family Incomes are between 246% and 305% of the most recent Federal Poverty Income Guidelines (Exhibit A), HPMC shall limit expected payments for Covered Services to an amount equal to forty-five percent (45%) of HPMC's undiscounted charges for the Covered Services provided to the patient less any payments made by the patient. HPMC has set the amount of expected payment for patients whose Family Incomes are between 246% and 305% of the most recent Federal Poverty Income Guidelines to be less than the greatest amount HPMC would expect to receive from Medicare, Medi-Cal or another government sponsored program of health benefits and shall annually review the discounted provided under this subsection so as to ensure that the expected payment is no greater than the greatest amount HPMC would

expect to receive from Medicare, Medi-Cal, or another government sponsored health program of health benefits in which HPMC participates.

d. For patients whose Family Incomes are between 350% and greater of the most recent Federal Poverty Income Guidelines (Exhibit A), HPMC shall limit expected payments for Covered Services to an amount equal to five percent (5%) of HPMC's undiscounted charges for the Covered Services provided to the patient less any payments made by the patient. HPMC has set the amount of expected payment for patients whose Family Incomes are between 350% and greater of the most recent Federal Poverty Income Guidelines to be less than the greatest amount HPMC would expect to receive from Medicare, Medi-Cal or another government sponsored program of health benefits and shall annually review the discounted provided under this subsection so as to ensure that the expected payment is no greater than the greatest amount HPMC would expect to receive from Medicare, Medi-Cal, or another government sponsored health program of health benefits in which HPMC participates.

4. Special Circumstances Charity Care. Special Circumstances Charity Care allows Uninsured Patients who do not meet the Financial Assistance Criteria set forth in Section 1 or 2 above, or who are unable to follow specified hospital procedures, to receive a complete or partial write-off of HPMC's undiscounted charges for Covered Services, with the approval of HPMC's [Chief Financial Officer] or his/her designee. HPMC must document the decision, including the reasons why the patient did not meet the regular criteria. The following is a non-exhaustive list of some situations that may qualify for Special Circumstances Charity Care:

a. Bankruptcy. Patients who are in bankruptcy or recently completed bankruptcy.

b. Homeless Patients. Emergency room patients without a payment source if they do not have a job, mailing address, residence or insurance.

c. Deceased. Deceased patients without insurance, an estate, or third-party coverage.

d. Medicare. Income-eligible Medicare patients may apply for Financial Assistance for denied stays, denied days of care, and Medicare cost

shares. Medicare patients who execute an Advance Beneficiary Notice of Noncoverage (ABN) shall not be eligible.

e. Medi-Cal. Income-eligible Medi-Cal patients may apply for Financial Assistance for denied stays, denied days or care, and non-covered services; however, patients may not receive Financial Assistance for the Medi-Cal Share of Cost. Persons eligible for programs such as Medi-Cal but whose eligibility status is not established for the period during which the medical services were rendered may apply for Financial Assistance.

5. High Medical Cost Charity Care. High Medical Cost Charity Care for Insured Patients ("High Medical Cost Charity Care") is a partial write-off of HPMC's undiscounted charges for Covered Services. High Medical Cost Charity Care is not available for patients receiving services that are already discounted (e.g., package discounts). For Covered Services provided to patients who qualify for High Medical Cost Charity Care, HPMC shall limit expected payments to an amount equal to twenty percent (20%) of the HPMC's undiscounted charges for the Covered Services provided to the patient less any payments made by the patient. This discount is available to insured patients who meet the following criteria:

   a. The patient's Family Income is less than 500% of the Federal Poverty Income Guidelines (Exhibit B);

   b. The patient's or the patient's family medical expenses for Covered Services (incurred at HPMC or paid to other providers in the past 12 months provided that the patient provides written evidence of payment to HPMC) exceed 10% of the patient's Family Income; and

   c. The patient's insurer has not provided a discount off the patient's bill (i.e., the patient is responsible to pay undiscounted charges).

Other Definitions

1. Covered Services:

   a. Covered Services for Full Charity Care are all services that are required to be covered by a Knox-Keene licensed Health Care Services Plan, except

that those services requiring administrative approval as defined below are not Covered Services.

b. Covered Services for Partial Charity Care and High Medical Cost Charity Care are all services provided by HPMC, except that those services requiring administrative approval as defined below are not Covered Services.

c. Services Requiring Prior Administrative Approval. Due to their unique nature, certain non-emergency services require administrative approval prior to admission and the provision of services. Generally, patients who seek complex, specialized, or high-cost services (e.g., experimental procedures, transplants) must receive administrative approval prior to the provision of services. Patients seeking to receive such services are not eligible for Full Charity Care, Partial Charity Care or High Medical Cost Charity Care unless HPMC's executive team makes an exception.

2. Uninsured Patient. An Uninsured Patient is a patient who has no source of payment for any portion of their medical expenses including, without limitation, commercial or other insurance, government sponsored healthcare benefit program or third-party liability, or whose benefits under insurance have been exhausted prior to admission.

3. Primary Language of HPMC's Service Area. A language is a primary language of HPMC's service area if 5% or more of HPMC's local population speaks the language.

4. Family Income. Family Income is annual family earnings from the prior 12 months or prior tax year as shown by recent pay stubs or income tax returns, less payments made for alimony and child support. Proof of earnings may be determined by annualizing year-to-date family income, giving consideration for current earning rates. For patients over 18 years of age, the patient's family income includes their spouse or domestic partner as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not. For patients under 18 years of age, the patient's family includes their parents, caretaker relatives, and other children under 21 years of age of the parents or caretaker relatives.

5. Federal Poverty Level (FPL). - The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under its statutory authority.

6. Amount Generally Billed (AGB). - The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. This is usually described as a percent of Gross Charges. The AGB percentages for each hospital facility are updated annually.

7. Out-of-Pocket Costs - Costs which the patient pays from personal funds.

Policy:

It is the policy of Hollywood Presbyterian Medical Center ("HPMC") to provide Financial Assistance, consistent with this policy, in the form of free or reduced cost care to eligible:

(1) **Low-income Uninsured Patients**
(Full Charity Care, Partial Charity Care, Special Circumstances Charity Care)

(2) **Patients with High Medical Costs**
(High Medical Cost Charity Care)

HPMC may also provide certain discounts for uninsured patients who do not otherwise qualify for Financial Assistance pursuant to a separate policy.

Procedures:

A. Applying for Financial Assistance:

1. An Uninsured Patient who indicates the financial inability to pay a bill for Covered Services shall be evaluated for Financial Assistance. To qualify as an Uninsured Patient, the patient or the patient's guarantor must verify that he or she is not aware of any right to insurance or government program benefits that would cover or discount the bill.

2. The "Statement of Financial Condition/Financial Assistance Application Form," **Exhibit B**, shall be used to document each patient's overall

financial condition. This application shall be available in the Primary Language(s) for HPMC's service area.

3. A sample of the "Charity Care Screening Form," **Exhibit C**, is provided to aid in the determination of the amount and type of charity care for which the patient may be eligible.

B. Financial Assistance Determination and Notice

1. Determination:

a. HPMC will consider each applicant's Financial Assistance application and grant Financial Assistance where the patient meets eligibility requirements and has received (or will receive) Covered Services.

b. HPMC will use a Third-Party Vendor to verify and qualify an applicant's most recent Federal Poverty Income Guidelines.

c. HPMC may make Financial Assistance approval contingent upon a patient applying for governmental program assistance, which may be prudent if the particular patient requires ongoing services.

d. In determining whether each individual qualifies for Financial Assistance, other county or governmental assistance programs should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medi-Cal, California Children Services, or other state-funded programs designed to provide health coverage.

e. HPMC should assist the individual in determining if they are eligible for any governmental or other assistance and provide applications as requested.

f. Where administrative approval is required, HPMC will consider the request for service in a timely fashion and provide a response to the request in writing.

2. Notice

   a. While it is desirable to determine the amount of Financial Assistance for which a patient is eligible as close to the time of service as possible, there is no rigid limit on the time when the determination is made. In some cases, eligibility is readily apparent while in other cases further investigation is required to determine eligibility. In some cases, a patient eligible for Financial Assistance may not have been identified prior to initiating external collection action. HPMC's collection agencies shall be made aware of this policy so that the agencies know to refer back to HPMC patient accounts that may be eligible for Financial Assistance.

   b. Once a Full or Partial Charity Care or High Medical Cost Charity Care determination has been made a "Notification Form" (**Exhibit D**) will be sent to each applicant advising them of the hospital's decision.

C. Dispute Resolution. In the event of a dispute over the application of this policy, a patient may seek review by notifying HPMC's Chief Financial Officer of the basis of any dispute and the desired relief. Written communication should be submitted within thirty (30) days of the patient's knowledge of the circumstances giving rise to the dispute. The Chief Financial Officer or his/her designee shall review the concerns and inform the patient of any decision in writing.

D. Recordkeeping. Records related to Financial Assistance must be readily accessible.

E. Third Party Liens. HPMC may lien the tort recoveries of Uninsured Patients in a manner consistent with applicable law.

F. Submission to HCAI. Beginning January 1, 2008 and every two years thereafter, HPMC's General Counsel will post this policy and any amendments or modifications thereto to the Department of Health Care Access and Information (HCAI) in a manner prescribed by HCAI.

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COMMUNICATION OF FINANCIAL ASSISTANCE AVAILABILITY

A. Information Provided to Patients

1. Preadmission or Registration. During preadmission or registration (or as soon thereafter as practicable and after stabilization of the patient's emergency medical condition in the case of emergency services), HPMC shall provide:

   a. All patients with information regarding the availability of Financial Assistance (Important Billing Information for Patients, **Exhibit E**).

   b. Patients who the hospital identifies as uninsured with a Financial Assistance application (**Exhibit B**).

2. Emergency Services. In the case of emergency services, HPMC shall provide the above information as soon as practicable after stabilization of the patient's emergency medical condition or upon discharge.

3. All Other Times. Upon request, HPMC shall provide patients with information about their right to request an estimate of their financial responsibility for services, the Statement of Financial Condition form, and/or Important Billing Information for Patients at HPMC.

B. Postings and Other Notices. Information about Financial Assistance shall also be provided as follows:

1. By posting in a visible manner in locations where there is a high volume of inpatient or outpatient admitting/registration, including, without limitation, the emergency department, billing offices, admitting office, and other hospital outpatient service settings.

2. By posting information about Financial Assistance on HPMC's website.

3. By including information about Financial Assistance in bills that are sent to Uninsured Patients. A sample that contains the required information is set forth on **Exhibit F**.

4. By including language on bills sent to Uninsured Patients as specifically set forth in **Exhibit G**.

C. Applications. HPMC shall make applications for Medi-Cal, California Children's Services or any other potentially applicable governmental program readily available and accessible to Uninsured Patients and provide such applications upon request.

D. Languages. All notices/communications provided in this section shall be available in the Primary Language(s) of HPMC's service area and in a manner consistent with all applicable federal and state laws and regulations.

COLLECTION ACTIVITIES

A. Assignment to Collection. No patient debt shall be advanced/assigned to collection until the [Director of Patient Financial Services] or his/her designee has reviewed the account and approved the advancement of the account to collection. If a patient is attempting to qualify for Financial Assistance and/or is attempting to settle an outstanding bill with HPMC by negotiating a reasonable payment plan or making regular payments of a reasonable amount, HPMC shall not send the unpaid bill to collection or a collection agency. Any extended payment plans shall be interest free.

B. Use of Collection Agencies. HPMC shall obtain an agreement from each collection agency that it utilizes to collect patient debt consistent with the requirements of this policy, federal law, and state law.

C. Collection Methods. HPMC shall not initiate legal or judicial process, sell a patient's debt to another party, or report adverse information about the patient to consumer credit reporting agencies or credit bureaus before HPMC has made reasonable efforts to determine whether the patient is eligible for Financial Assistance and in no case shall HPMC or any collection agency utilized by HPMC shall report adverse information to a consumer credit reporting agency or commence civil action against the patient for non-payment at any time prior to 150 days after the initial billing if the patient is an Uninsured Patient or a patient provides information that he or she may qualify for Financial Assistance. The 150-day period shall be extended if the patient has a pending appeal for coverage for the services and the patient makes a reasonable effort to keep HPMC informed of the progress of any appeals.

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References:

California Hospital Fair Pricing Law SB1276

California Department of Public Health AFL 14-25-1

Federal Poverty Level (FPL) - Glossary | HealthCare.gov

Exhibit A

FPL Sliding Scale	0% - 200%	201% - 245%	246% - 305%	306% - 349%	350% and greater
Discount%	100%	80%	45%	15%	5%
Required P	0%	20%	55%	85%	95%

*Federal Poverty Level (FPL) - Glossary | HealthCare.gov

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Exhibit B
STATEMENT OF FINANCIAL CONDITION/FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME _____ SPOUSE _____
ADDRESS _____
PHONE _____
ACCOUNT # _____ SSN: _____ _____
(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support

Name	Age	Relationship
_____	____	_____
_____	____	_____
_____	____	_____

EMPLOYMENT AND OCCUPATION
Employer: _____ Position: _____
Contact Person & Telephone Number: _____
If Self-Employed, Name of Business: _____

Spouse Employer: _____ Position: _____
Contact Person & Telephone Number: _____
If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

		Patient	Spouse
	Gross Pay (Before Deductions)	_____	_____
Add:	Income from Operating Business (if Self-Employed)	_____	_____
Add:	Other Income Interest & Dividends From Real Estate Social Security Other (Specify) Alimony or Spousal Support	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____
Subtract:	Alimony, Support Payments Paid	_____	_____
Equals	Current Monthly Income	_____	_____

Total Current Monthly Income (Patient + Spouse) = $ _____

FAMILY SIZE
Total Family Members: _____
(add patient, spouse and dependents from above)

	Yes	No
Do you have health insurance?	_____	_____
Are you eligible for any government programs?	_____	_____
Do you have other insurance that may apply (such as auto policy)?	_____	_____
Were your injuries caused by a third party? (such as during car accident)?	_____	_____

By signing this form, I agree to allow HPMC to check employment status and credit history for the purpose of determining my eligibility for financial assistance. I understand that I may be required to provide proof of the information I am providing.

_____ _____
(Signature of Patient or Guarantor) Date

_____ _____
(Signature of Spouse) Date

Exhibit C

HOLLYWOOD PRESBYTERIAN MEDICAL CENTER

Charity Care Screening Form

Request for Financial Assistance/Uncompensated Services

Hollywood Presbyterian Medical Center's (HPMC's) Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs with low-income, uninsured or underinsured, ineligible for a government program, and is otherwise unable to pay for medically necessary care based on their individual family financial situation.

To determine if a patient/guarantor 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 complete the questionnaire below and return with copy(s) of your pay-check stub and bank statement.

Name _____ **Guarantor/Account #** _____
Address _____ **Phone number** _____
_____ **Social Security No.** _____

Date of Birth / / **Sex** _____ (M=Male/F=Female) **Do you own a home?** **Yes** **No**
Number of dependents filed on tax return: _____ **Do you own other property?** **Yes** **No**
Do you own automobiles? **Yes** **No**

List dependents:

Name	Relationship	Age	Gender

INCOME: (Please provide photocopies of pay-checks and bank statements and list income)

	Monthly	Annual
Wages (Self)		
(Spouse)		
(Other Family Member)		
Self-Employment		
Public Assistance		
Social Security		
Unemployment Compensation		
Retirement		
Alimony /Child Support		
Military Family Allotments		
Pensions		
Income from Dividends, Interest, Rent		

EXPENSES (Monthly)		BANKING INFORMATION	
Mortgage / Rent (1)		Checking Account #	
Utilities		Balance	
Telephone		Savings Account #	
Food		Balance	
Finance / other loans			
Auto Loans			
Other		Medical Bills	
Total Expenses			

(1) If none, source of housing: _____

- I declare under penalty of perjury that the answers I have given are true and correct to the best off my knowledge.
- I agree to tell the provider of services, within 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 in the household or of any change of addresses.
- I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with my employer, bank, credit verification and property searches.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the hospital from proceeds off any litigation or settlement resulting from such act.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the services rendered by UC Irvine Health or I may appeal decision in writing with additional documentation.

_____ _____
Signature **Date**

Exhibit D

NOTIFICATION FORM

ELIGIBILITY FOR CHARITY CARE

HPMC has conducted an eligibility determination for charity care for:

_____	_____	_____
PATIENT'S NAME	ACCOUNT NUMBER	DATES OF SERVICE

The request for charity care was made by the patient or on behalf of the patient on _____.

The determination was completed on _____.

Based on information supplied by the patient or on behalf of the patient, the following determination has been made:

Your request for charity care has been approved for services rendered on _____.
After applying the charity care reduction, the amount owed is $_____.

Your request for charity care is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____
_____
_____
_____
_____

Your request for charity care has been denied because:

REASON:

_____
_____
_____
_____
_____
_____

Granting of charity care is conditioned on the completeness and accuracy of the information provided to the hospital. In the event the hospital discovers you were injured by another person, you have additional income, you have additional insurance or provided inaccurate information regarding your ability to pay for the services provided, the hospital may revoke its determination to grant charity care and hold you and/or third parties responsible for the hospital's charges. If you have any questions on this determination, please contact _____ at _____.

Exhibit E
Important Billing Information for Patients at HPMC

Thank you for choosing HPMC for your hospital services. The information below is designed to help you understand options available to assist patients pay their hospital bill. This information only applies to your hospital bill and does not include any bills received from physicians, anesthesiologists, clinical professionals, ambulance companies, etc., that may bill you separately for their services.

An emergency physician, as defined in California Health & Safety Code § 127450, who provides emergency medical services at HPMC is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 % of the federal poverty level. You will receive a separate bill for the emergency physician services as well. Any questions pertaining to the emergency physician services should be directed to the physician providing the services as represented on the billing statement. The contact information for the emergency physician is as follows:

Hollywood Presbyterian Emergency Medical Associates, Inc.
[Name of Billing Service]
[Address of Billing Service]
[Address]
[City, State, Zip]
[Phone Number]
E-mail: [_____]

Payment Options

HPMC has many options to assist you with payment of your hospital bill.

Medi-Cal & Government Program Eligibility. You may be eligible for a government sponsored health benefit program. HPMC has staff available to assist you with applying for government assistance like Medi-Cal, and California's Children Services to pay your hospital bill. HPMC also contracts with a company that may assist you further, if needed.

Financial Assistance Program (Charity & Discount Care). Uninsured patients who have an inability to pay their bill may be eligible for financial assistance. Eligibility for financial assistance is based on income and family size. All potential payer sources must be exhausted before a patient is eligible for financial assistance. Copies of HPMC's Financial Assistance Policy, applications for financial assistance, and applications for government programs are available at Patient Registration and our [Patient Financial Services Office]. We can also send you copies if you contact our [Patient Advocate Specialist] at _____.

If you have any questions, or if you would like to pay by telephone, please contact the [Patient Advocate Specialist] at _____.

Exhibit F
NOTICE OF RIGHTS

Thank you for selecting HPMC for your recent services. Enclosed please find enclosed a statement the charges for your hospital visit. Payment is due immediately. Please be aware that this the bill for hospital services only. There may be additional charges for services that will be provided by physicians during your stay in the hospital such as bills from personal physicians and any anesthesiologists, pathologists, radiologists, ambulance companies or other medical professionals who are not employees of the hospital. You may receive a separate bill for these services.

An emergency physician, as defined in California Health & Safety Code § 127450, who provides emergency medical services at HPMC is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 % of the federal poverty level. You will receive a separate bill for the emergency physician services as well. Any questions pertaining to the emergency physician services should be directed to the physician providing the services as represented on the billing statement. The contact information for the emergency physician is as follows:

Hollywood Presbyterian Emergency Medical Associates, Inc.
[Name of Billing Service]
[Address of Billing Service]
[Address]
[City, State, Zip]
[Phone Number]
E-mail: [_____]

Our records indicate that you do not have health insurance coverage or coverage under Medicare, Medi-Cal, Healthy Families, or other similar programs. If you have such coverage, please contact our [Patient Accounts Financial Advocate] at _____ as soon as possible so the information can be obtained, and the appropriate entity billed.

HPMC has many options to assist you with payment of your hospital bill.

Medi-Cal & Government Program Eligibility. You may be eligible for a government sponsored health benefit program. HPMC has staff available to assist you with applying for government assistance like Medi-Cal, and California's Children Services to pay your hospital bill. HPMC also contracts with a company that may assist you further, if needed.

Financial Assistance Program (Charity Care). Uninsured patients who have an inability to pay their bill may be eligible for financial assistance. Eligibility for financial assistance is based on income and family size. All potential payer sources must be exhausted before a patient is eligible for financial assistance. Copies of HPMC's Financial Assistance Policy, applications for financial assistance, and applications for government programs are available at Patient Registration and our [Patient Financial Services Office]. We can also send you copies if you contact our [Patient Advocate at Specialist] at _____.

If you have any questions, or if you would like to pay by telephone, please contact the [Patient Advocate Specialist] at _____.

Exhibit G

NOTICE LANGUAGE ON BILLS FOR UNINSURED PATIENTS

Our records indicate that you do not have health insurance or coverage under Medicare, Medi-Cal, or similar other programs. Patients who lack insurance and meet certain income requirement may qualify for financial assistance. Please contact the [Patient Advocate Specialist] at _____ to obtain further information.