# ARIZONA FINANCIAL ASSISTANCE APPLICATION MATERIALS

Billing Insert

Banner Health
*New directions in healthcare*

# FINANCIAL ASSISTANCE IS AVAILABLE

Banner Health offers a variety of payment options and financial assistance programs. If you are unable to pay your balance in full at this time, please contact our office at **602-640-3100 or 800-423-2928, press option 3.**

# SELF PAY
# Fact Sheet

**This fact sheet has been created to advise you of vital information pertaining to your specific insurance coverage. Please read these items below. If you have any questions, your Patient Account Representative will be happy to assist you or you can call our Patient Financial Services (PFS) Office at 530-252-2253 or 530-252-2254.**

- If you cannot pay the balance in full, you must speak with one of our Patient Account Representatives to discuss your account balance. Please refer to the payment options listed below.
- Delinquent accounts – Self pay balances, for which no definite arrangements were made and have received 3 statements, will be considered for turnover to a collection agency.

**It is important that you call our office within 30 days of your first self-pay statement to discuss the payment options below:**

### Option #1 – Prompt Pay Discount

We offer a prompt pay discount for balances paid in full within 30 days of the first self-pay statement. The discount must be made prior to payment and documented so the proper adjustment can be made in the system. There will be no refunds unless the request was made in advance and in writing.

For charges less than $500 – 10% discount
For charges between $500 - $5,000 – 15% discount
For total charges greater than $5,000 – 20% discount

### Option #2 – Payment Arrangements

You can make arrangements to pay your bill in monthly installments. Your payment amount and terms will be determined by the amount of the account balance.

| BALANCE | PAYMENT SCHEDULE |
|---|---|
| 0- 100 | 2 EQUAL PAYMENTS |
| 101- 500 | 6 EQUAL PAYMENTS |
| 501-1000 | 10 EQUAL PAYMENTS |
| 1001-2000 | 12 EQUAL PAYMENTS |
| 2001-2500 | 15 EQUAL PAYMENTS |
| OVER 2500 | 24 EQUAL PAYMENTS |

### Option #3 – Financial Assistance

We will be happy to see if you qualify for additional financial assistance. Contact our Patient Account Representative to fill out the necessary paperwork. You should first apply for Medi-Cal however if you cannot meet the requirements for Medi-Cal you may still qualify for the BLMC financial assistance program.

**Statements:** You will receive monthly statements. Please read them carefully for account information, current account balance, payments posted, and the custom message section on the bottom.

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Banner Health

Patient Financial Services
P.O. Box 18, Phoenix, AZ 85001-9932
602-640-3100

# To Our Patients Applying For The Financial Assistance Program:

In order for us to consider your application we must receive **ALL** the documents listed below. Be advised all information provided is kept confidential.

**Please provide the following:**

- ☐ The completed blue financial assistance application.
- ☐ A copy of your prior year's tax return including schedule C if self-employed.
- ☐ If employed, four consecutive weeks copies of your current paycheck stubs.
- ☐ Copies of your last three bank statements; checking and savings accounts.
- ☐ Copies of any outstanding medical bills including doctor bills, ambulance etc.
- ☐ A copy of the State Assistance program (AHCCCS) decision notice.

**NOTE:** *"Failure to provide information or failure to participate in the interview" is not acceptable and cannot be used in this application.*

**Completing the application is not a guarantee you will be approved for financial assistance and our collection process will continue.**

Please return the additional information as soon as possible or contact our office to discuss your account. You may reach me at (602) 640-3601 or toll free number of 1-800-423-2928 option 2, Monday through Friday 8:00 a.m. till 4:00 p.m. Thank you.

Sincerely,

*Gina Marquez-Ocano*
Financial Assistance Representative
Banner Health; Patient Financial Services

Banner Health®

Patient Financial Services
P.O. Box 18, Phoenix, AZ 85001-9932
602-640-3100

## A Pacientes Solicitando Nuestro Programa Financiero de la Reducción:

En la orden para nosotros considerar su aplicación usted debe mandar todos los documentos listaron abajo. La información recibida permanecerá confidencial. Esté enterado que nuestro proceso de la colección continuará durante este tiempo de la aplicación.

**Proporcione por favor:**

- ☐ La completada aplicación de asistencia financiera.
- ☐ Una copia de sus declaraciones de impuestos del anterior, incluye el horario C si empleo por uno mismo.
- ☐ Si empleó, copias de sus talones de cheques de trabajo para cuarto semanas.
- ☐ Copias de sus últimos tres estados del banco; cheques y de ahorros.
- ☐ Copias de alguna cuenta médica sobresaliente inclusive doctor, de ambulancia, etc.
- ☐ Una copia de la decisión del programa (AHCCCS) de ayuda de estado/nota de negación. **NOTA**: *"el fracaso para proporcionar información o fracaso para tomar parte en la entrevista"* no es aceptable y no puede ser utilizado en esta aplicación.

**Sea avisado completar la aplicación no es una garantía que usted se aprobará para una reducción financiera encargadas.**

Por favor de regresar la información completa lo pronto posible. Si usted necesita asistencia usted me puede contactar en (602) 640-3601, Lunes a Viernes de las 8:00 de la mañana hasta 4:00 de la tarde.

Gracias para su cooperación y su pronto atención.

Sinceramente,

*Gina Márquez-Ocano*
Representante Financiero de Reducción
Banner Health; Patient Financial Services

Banner Health.

ACCOUNT #: _____

PATIENT NAME: _____

# FINANCIAL STATEMENT

| LAST NAME (RESPONSIBLE PARTY) | FIRST | MIDDLE | SOC SEC # | BIRTHDATE |
|---|---|---|---|---|
| MAILING ADDRESS | | | HOW LONG | PHONE |
| CITY | | STATE | | ZIP |

| | | |
|---|---|---|
| PATIENT IF DIFFERENT FROM ABOVE | | |
| RESPONSIBLE PARTY EMPLOYER (NAME & FULL ADDRESS) | | |
| | PHONE | MONTHLY GROSS PAY $ |
| OTHER EMPLOYER (NAME & ADDRESS) | | |
| | PHONE | MONTHLY GROSS PAY $ |
| IF UNEMPLOYED NAME LAST EMPLOYER (NAME & ADDRESS) | | |
| | | LAST EMPLOYMENT DATE |

| | FAMILY MEMBERS | BIRTHDATE | RELATIONSHIP | EMPLOYED BY | EMPLOYER PHONE # |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

☐ RENT ☐ OWN

| OTHER MONTHLY INCOME | $ | (SPECIFY SOURCE) |
|---|---|---|

| OWED TO OTHERS | To Whom Owed | PRESENT BALANCE | MONTHLY PAYMENT | ASSETS | Bank Name & Account Number | BALANCE OF ACCOUNT |
|---|---|---|---|---|---|---|
| RENT/ MORTGAGE | | | | CHECKING | | $ |
| UTILITIES | | | | SAVINGS OR CERTIFICATE | | |
| FOOD | | | | 401K PLAN | | |
| AUTO LOAN | | | | STOCKS & BONDS | | |
| AUTO INSURANCE | | | | IRA | | |
| CREDIT CARDS | | | | AUTO (YEAR & MAKE) | | |
| | | | | AUTO (YEAR & MAKE) | | |
| | | | | RESIDENCE-MARKET VALUE | | |
| Other obligations (Example Insurance Payments, Child Support, Alimony) | | | | INSURANCE CASH VALUE | | |
| *ADDITIONAL INFORMATION SEE BACK | | | | OTHER ASSETS DESCRIBE | | |
| | | | | | | |
| | | | | TOTAL ASSETS | | |

**PLEASE COMPLETE AND SIGN THE REVERSE SIDE**

Banner Health®

NUMERO DE CUENTA: _____

NOMBRE DEL PACIENTE: _____

# DECLARACIÓN FINANCIERA

| APELLIDO (LA PERSONA RESPONSABLE) | NOMBRE | SEGUNDA NOMBRE | NUMERO DE SEGURO SOCIAL | FECHA DE NACIMIENTO |
|---|---|---|---|---|
| DOMICILIO | | HACE CUANTO TIEMPO | TELÉFONO | |
| CIUDAD | ESTADO | | CÓDIGO POSTAL | |

| | | |
|---|---|---|
| PACIENTE - LLAME SOLAMENTE SI ES DIFERENTE | | |
| EMPLEADOR DE LA PERSONA RESPONSABLE DE LA CUENTA FINANCIERA (NOMBRE Y DIRECCIÓN) | | |
| | TELÉFONO | SALARIO MENSUAL ANTES DE IMPUESTOS $ |
| OTRO EMPLEADOR (NOMBRE Y DIRECCIÓN) | | |
| | TELÉFONO | SALARIO MENSUAL ANTES DE IMPUESTOS $ |
| SI NO TIENE EMPLEO CITE SU ULTIMO EMPLEADOR (NOMBRE Y DIRECCIÓN) | | |
| | | ULTIMA FECHA QUE TRABAJO |

| | MIEMBROS FAMILIARES | FECHA DE NACIMIENTO | PARENTESCO | EMPLEADO POR | NUMERO DE TELÉFONO TRABAJO |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

☐ RENTA ☐ PROPIETARIO

| OTRO INGRESO MENSUAL | $ | (ESPECIFIQUE DE DONDE SE OBTIENE) |
|---|---|---|

| DEUDAS A QUIEN | BALANCE ACTUAL | PAGO MENSUAL | BIENES DISPONIBLES NOMBRE DEL BANCO Y NUMERO DE CUENTA | BALANCE DE SU CUENTA |
|---|---|---|---|---|
| RENTA/ HIPOTECA | | | CUENTA DE CHEQUERA | $ |
| SERVICIOS DE LUZ, AGUA ETC. | | | CUENTA DE AHORRAS O CERTIFICADO | |
| COMIDA | | | PLAN DE 401K | |
| PRÉSTAMO DE AUTOMÓVIL | | | BONOS Y ACCIONES | |
| SEGURO AUTOMOVILISTICO | | | IRA | |
| TARJETAS DE CRÉDITO | | | AUTO (ANO Y MANUFACTURA) | |
| | | | AUTO (ANO Y MANUFACTURA) | |
| | | | VALOR RESIDENCIAL | |
| OTRAS OBLIGACIONES (EJEMPIO: PAGOS DE SEGURO, ASISTENCIA DE DIVORCIO, MANUTENCIÓN DE MENORES | | | SEGURO - VALOR EN EFECTIVO | |
| *INFORMACIÓN ADICIONAL VEA AL DORSO | | | OTROS BIENES | |
| | | | | |
| | | | BIENES TOTALES | |

**Por Favor Llene Y Firme Al Dorso De Esta Forma**