CREDIT AND COLLECTION PROCEDURES

I. PURPOSE: The concept of credit and collections in the hospital field s a difficult one. It must be developed to meet both the public relations of the community and financial requirements of the hospital itself. It is important to respect the community and constantly be aware of the image of the hospital in the community. However, it is critically important to assure the hospital of adequate cash flow. A good collections procedure is a must. A good collection program should be preceded by a detailed admitting procedure, prompt verification, sound financial arrangements and timely billing procedures. It is of prime concern that the patient will leave the hospital with positive feeling about the manner in which their financial affairs were handled for all services rendered to them in the hospital atmosphere.

II. HOSPITAL COLLECTION PERSONNEL:

A. Must be friendly and outgoing.
B. Understand the hospital payment policy.
C. Be able to explain the hospital charges for services in a manner that billing is understandable to the patient.

III. HOSPITAL COLLECTION POLICY:

A. Establish a payment plan.
B. Determine a required admission and/or discharge plan.
C. When the account is to be billed.
D. When the account is to be followed up.
E. When the account is to be considered a collection problem.
F. What action is to be taken if a problem account is suspected.

IV. FUNCTIONS OF COLLECTION PERSONNEL:

A. Assist those patients who intend to pay.
B. Instill a desire to pay in the patient.
C. Assist in the financial arrangements with a patient to fulfill his obligation to the hospital.

V. COLLECTION RESPONSIBILITY

A. The collection procedure will be the responsibility of the Business Office Manager. The Administrator and CFO will be consulted at all items in the direction and decisions of this procedure.

COLLECTION PROCEDURE

I. PRIVATE PAY

A. Patient will be billed on the day following the posting of the service.
B. If payment is not received within 35 days, letter #1 will be sent to the guarantor.
C. If payment is not received within 10 days after letter #1 has been sent, the office manager will attempt to contact the guarantor by phone. If phone contact is not possible, or if the guarantor indicates that he is not desirous of meeting his obligation, letter #2 will be sent.
D. If payment has not been received, or if the guarantor has not made arrangements for payments on the 120th day the account will be sent to the collection agency.

II. PRIVATE PATIENTS WITH INSURANCE

A. Insurance Company will be billed within 15 days following the date of service.
B. If payment has not been received from the insurance company in 30 days, the patient will be billed with a note requesting that they contact their insurance company or remit payment to the hospital.
C. If payment has not been received within 40 days letter #1 and a phone call will be made to the guarantor requesting that he contact the insurance company. If phone contact with the guarantor is not possible, a call will be made to the insurance company.
D. If payment is not received or arrangement for payment has not been made within 50 days letter #2 will be sent to the guarantor.
E. After the insurance company has paid, if there is a balance due, the billing will be sent to the guarantor and this will be treated as a "Private Pay Patient" (see I).

III. MEDICARE PATIENTS

A. Medicare will be billed within 15 days following the date of service.
B. After Medicare has paid, any balance due (deductibles or co-ins) will be billed to the patient unless the patient has a supplementary insurance policy, then the balance will be billed to this insurance. After insurance has paid, any balance due will be sent to the patient for payment.
C. If the patient has not made payment within 45 days following the date of payment by Medicare or insurance, letter #3 will be sent to the patient.
D. Medicare patients who do not pay their deductibles or co-insurance amounts will be referred to the Collection Agency after three monthly statements or 120 days.

IV. MEDICAL PATIENTS:

A. MediCal will be billed within 15 days following the date of service.
B. If the patient has not provided the Business Office with a MediCal card, the patient wil be billed within 2 days from the date of service.
C. If, within 5 days from the date of service, the patient has not provided a valid card, the account will be handled as a private pay account. (See I)
D. If the MediCal covered patient has a share of cost obligation, this amount will be treated as a private pay account. (See I).

V. ACCOUNTS SENT FOR COLLECTION

A. Inpatient accounts sent to the collection agency:

1. Up to $1,000, approval required by the CFO.
2. $1,000 to $5,000 approval required by CFO and Administrator.
3. Accounts of $5,000 and over must be approved by the CFO, Administrator and the Board of Directors.

B. Outpatient accounts sent to the collection agency:

1. Accounts up to $500 must be approved by the CFO.
2. Accounts $500 to $1,000 must be approved by the CFO and the Administrator.
3. Accounts of $1,000 and over must be approved by the CFO, Administrator and the Board of Directors.

VI. WRITE OFF POLICY

A. Accounts which have received all normal follow-up, in-house collection efforts, and collection agency's efforts and which fail to respond will be considered as bad debts. These accounts will be written off on a quarterly basis.

B. Remaining account balances, when the patient has expired, and there is no estate, will be written off as charity care.

C. Uncollectible balances under $5 will be written off with the approval of the CFO. These are referred to as "Small Balance Write-Off's".

D. Any account (with the exception of Small Balance Write-Off's), prior to being written off, will be reviewed and approved by the CFO and the Administrator.

E. All Medicare/MediCal crossover deductibles and co-insurance, inpatient and outpatient, will be billed to MediCal after Medicare payment is received. All MediCal cutbacks will be recorded in a log and written off as Medicare bad debt.