Credit & Collection Policy

CHC NAME: _Manet Community Health Center
Contact Name: Gail Covelluzzi Title: CFO
Contact Phone: 617-690-6353 Email:_gcovelluzzi@manetchc.org
CFO Name: Gail Covelluzzi Email: _gcovelluzzi@manetchc.org

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1. General Filing Requirement *613.08(1)(c*

1.1 The Manet Community Health Center will electronically file its Credit & Collection Policy with the Health Safety Net (HSN) Office within 90 days of adoption of amendments to this regulation that would require a change in the Credit & Collection Policy; when the health center changes its Credit & Collection Policy; or when requested by the HSN Office.

2. General Definitions *613.02*

2.1 *Emergency Services - NIA*

2.2 The Urgent Care Services Definition used to determine allowable Bad Debt under *613.06 is:* Medically necessary services provided in a Hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing a patient's health injeopardy; impairment to bodily function; or dysfunction of any bodily organ or part. Urgent care services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual'shealth. Urgent care services do not include elective or primary care.

3. General Collection Policies & Procedures *613.08(J)(c)2 and 613.04(6)(c)3*

3.1 Standard Collection Policies and Procedures for patients *613.08(J) (c) 2a*

(a) The health center makes reasonable efforts prior to or during treatment to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor. The center's staff provides all first-time patients with a registration form which includes questions on the patient's insurance status, residency status, and financial status, and provides assistance, as needed, to the patient in completing the form.

A patient who states that they are insured will be requested to provide evidence of insurance sufficient to enable the center to bill the insurer. Health center staff ask returning patients, at the time of visit, whether there have been any changes in their income or insurance coverage status. If there has been a change, the new information is recorded in the center's practice management system and the patient advised or assisted to inform MassHealth of the change.

(b) The health center undertakes the following reasonable collection efforts for patients who have not provided complete eligibility documentation, or for whom insurance payment may be available:

(1) an initial bill is sent to the party responsible for the patient's financial obligations;

(2) subsequent billings, telephone calls, and any subsequent notification method that constitute a genuine effort to contact the party which is consonant with patient confidentiality are sent;

(3) efforts to locate the patient or the correct address on mail returned as an incorrect address are documented, and

(4) a final notice is sent by certified mail for balances over $1000, where notices have not been returned as an incorrect address or as undeliverable.

(c) Cost Sharing Requirements. Health center staff inform patients who are responsible for paying co-payments in accordance with 101 CMR 613.04 (6)(b) and deductibles in accordance with 101 CMR 613.04(6)(c), that they will be responsible for these co-payments.

(d) Low Income Patient Co-Payment Requirements. The health center requests co-payments of $1 for antihyperglycemic, antihypertensive, and antihyperlipidemic generic prescription and $3.65 for generic and brand-name drugs from all patients over the age of 18, with the exception of pregnant or postpartum women, up to a maximum pharmacy co-payment of $250 per year.

(e) Health Safety Net - Partial Deductibles/Sliding Fees: For Health Safety Net - Partial Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPL, the health center determines their deductible (40% of the difference between the lowest MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), in the applicant's Premium Billing Family Group (PBFG) and 200% of the FPL). If any member of the PBFG has an FPL below 150.1 % there is no deductible for any member of the PBFG. The Patient is responsible for 20% of the HSN payment for all services, with the exception of pharmacy services, provided up to this Deductible amount. Once the Patient has incurred the Deductible, the patient is no longer required to pay 20% of the payment. Only one deductible is allowed per PBFG approval period.

3.2 Policies & Procedures for Collection Financial Information from patients *613.08(l)(c)2b*

All patients who wish to apply for HSN or other public coverage are required to complete and submit a MassHealth/Connector Care Application using the eligibility procedures and requirements applicable to MassHealth applications under 130 CMR 502.000 or 130 CMR 515.000.

(a) Determination Notice. The Office of Medicaid or the Commonwealth Health Insurance Connector will notify the individual of his or her eligibility determination for MassHealth, Commonwealth Care, or Low Income Patient status.

(b) The Division's Electronic Free Care Application issued under 101 CMR 613.04(2)(b)(3) may be used for the following special application types:

a. Minors receiving Services may apply to be determined a Low Income Patient using their own income information and using the Division's Electronic Free Care Application. If a minor is determined to be a Low Income Patient, the health center will submit claims for confidential Services when no other source of funding is available to pay for the services confidentially. For all other services, minors are subject to the standard Low Income Patient Determination process. *613.04(3)a*

b. An individual seeking eligible services who has been battered or abused, or who has a reasonable fear of abuse or continued abuse, may apply for Low Income Patient status using his or her own income information. Said individual is not required to report his or her primary address. *613.04(3)b*

Presumptive Determination. An individual may be determined to be a Low Income Patient for a limited period of time, if on the basis of attested information submitted to the health center on the form specified by the Health Safety Net Office, the Provider determines the individual is

presumptively a Low Income Patient, The health center willl submit claims for Reimbursable Health Services provided to individuals with time limited presumptive Low Income Patient determinations for dates of service beginning on the date on which the Provider makes the presumptive determination and continuing until the earlier of: a. The end of the month following the month in which the Provider made the presumptive determination if the individual has not submitted a complete Application, or b. The date of the determination notice described in 101 CMR 613.04(2) (a) related to the individual's Application. *613.04 (4)*

3.3 Emergency Care Classification - NA

3.4 Policy for Deposits and Payment Plans *613.08(1)(c)2d*

The health center's billing department provides and monitors Deposits and Payment Plans as described in Section 5 of this policy for qualified patients as described in IO1 CMR 613.08. Each payment plan must be authorized by the Billing Manager.

3.5 Copies of Billing Invoices and Notices of Assistance *613.08(1)(c)2e*

(a) Billing Invoices: The following language is used in billing statements sent to low income patients: "If you are unable to pay this bill, please call (phone #). Financial assistance is available."

(b) Notices: The Health center provides all applicants with notices of the availability of financial assistance programs, including MassHealth, subsidized Health Connector Programs, HSN and Medical Hardship, for coverage of services exclusive of personal convenience items or services, which may not be paid in full by third party coverage. The center also includes a notice about Eligible Services and programs of public assistance to Low Income Patients in its initial invoices, and in all written Collection Actions. All applicants will be provided with individual notice of approval for Health Safety Net or denial of Health Safety Net once this has been determined. The following language is used on billing statements sent to low income patients: "If you are unable to pay this bill, please call (phone #). Financial assistance is available." The Health center will notify the patient that the Provider offers a payment plan if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

(c) Signs: The Health center posts signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance and programs of public assistance and the office at which to apply for such programs. Signs will be large enough to be clearly visible and legible by patients visiting these areas. All signs and notices will in English.

3.6 Discount/Charity Programs for the Uninsured *613.08(J)(c)2f*

The health center offers Sliding Fee Discounts to patients who are ineligible for the Health Safety Net. For these patients, the health center offers full discount to patients under 100% of the Federal Poverty Income Guidelines (FPIG) and Sliding Fee Discounts to patients with incomes between 100% and 150.1% of the FPIG. and $25 for patients with incomes between 250% and 400% of the FPIG.

3.7 Hospital deductible payment option at HLHC - NA

3.8 Full or 20% Deductible Payment Option for all Partial HSN Payments at HLC H Satellite or Student Health Center – NA

3.9 Community Health Center (CHC) charge of 20% of deductible per visit to all partial HSN patients *613.04(6)(c)5a*
The health center charges HSN-Partial Low Income Patients 20% of the HSN payment for each visit, to be applied to the amount of the Patient's annual Deductible until the patient meets the Deductible.
3.10 Direct Website(s) (or URL(s)) where the provider's Credit & Collection Policy, Provider Affiliate List (if applicable) and other financial assistance Policies are posted
www.manetchc.org

3.11 Provider Affiliate List effective the first day of tile acute Hospital's fiscal year beginning after December 31, 2016 - NA

4. Collection of Financial Information 613.06 *(l) (a)*
4.1 Inpatient, Emergency, and Outpatient & CHC Services: *613.06(l) (a) 1* The Health center makes reasonable efforts, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor.
4.2 Inpatient Verification - NA
4.3 Outpatient/CBC Financial Verification 613.06 *(l) (a) 2b*
The Health center makes reasonable efforts to verify patient-supplied information at the time the patient receives the services. The verification of patient-supplied information may occur at the time the patient receives the services or during the collection process as defined below:
1. Verification of gross monthly-earned income is mandatory. When possible this is done through electronic data matching using the eligibility procedures and requirements under 130 CMR 502 or 516. If the information received is not compatible or is unavailable, the following are required:
a. Two recent pay stubs;
b. A signed statement from the employer; or
c. The most recent U.S. tax return.
2. Verification of gross monthly-unearned income is mandatory and shall include, but not be limited to, the following:
a. A copy of a recent check or pay stub showing gross income from the source;
b. A statement from the income source, where matching is not available;
c. The most recent U.S. Tax Return.
3. Verification of gross monthly income may also include any other reliable evidence of the applicant's earned or unearned income.

5. Deposits and Payment Plans *613.08(1)(/)*
5.1 The health center does not require pre-treatment deposits from Low Income patients. *613.08(l)(g)l*

5.2 Deposit Requests for Low Income Patients: The Health center does not require a deposit from individuals determined to be Low Income Patients *613.08(l)(g)2*

5.3 Deposit Requirement for Medical Hardship Patients: The Health center does not require a deposit from patients eligible for Medical Hardship. *613.08(1)(g)3*

5.4 Interest Free Payment Plans on Balances less than, and greater than, $1000.The Health center will offer payment plans to Low Income and Medical Hardship patients with balances interest-free payment plans with monthly payments of no more than $25. If the balance is less than $1000, this will be for one year; if it is greater than $1,000 it will be for two years. . *613.08(J) (g) 4*

6. Populations Exempt from Collection Action *613.08(3)& 613.05(2)*

6.1 MassHealth, Emergency Aid to the Elderly, Disabled, and Children EAEDC enrollees: The health center does not bill patients enrolled in MassHealth, patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, except that the health center may bill patients for any required co-payments and deductibles. The Health center may initiate billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in any of the above listed Programs, and receipt of the signed application, the Health center will cease its collection activities. *613.08(3) (a)*

6.2 Participants in Children's Medical Security Plan (CMSP) with Modified Adjusted Gross Income (MAGI) under 300% FPL: are also exempt from Collection Action. The Health center may initiate billing for a patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in the Children's Medical Security Plan, the Health center will cease all collection activities. *613.08(3)(b)*

6.3 Low Income Patients except Dental-only Low Income Patients.

Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income equal or less than 150.1% of the FPL, are exempt from Collection Action for any Eligible Services rendered by the Health center during the period for which they have been determined Low Income Patients, except for co-payments and deductibles. The Health center may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients, after their Low Income Patient status has expired or otherwise been terminated. *613.08(3)(c)*

6.4 Low Income Patients with HSN Partial

Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 200.1% and 300.1% of the FPL are exempt from Collection Action for the portion of their bill that exceeds the Deductible and may be billed for co-payments and deductibles as set forth in 101 CMR 13.04(6) (b) and (c). The Health center may continue to bill Low Income Patients for services rendered prior to their determination as Low Income Patients, after their Low Income Patient status has expired or otherwise been terminated. *613.08(3) (d)*

6.5 Low Income Patient Consent to billing for non-reimbursable services: The Health center may bill Low Income Patients for services other than Eligible Services provided at the request of the patient and for which the patient has agreed in writing to be responsible. 613.08(3)(e)

6.6 Low Income Patient Consent Exclusion for Medical Errors, including Serious Reportable Events (SRE

The health center will not bill low income patients for claims related to medical errors occurring on the health center's premises. *613.08(3) (e) 1*

6.7 Low Income Patient Consent Exclusion for Administrative or Billing Errors The health center will not bill Low Income Patients for claims denied by the patient's primary insurer due to an administrative or billing error. *613.08(3)(e)2*

6.8 Low income Patient Consent for CommonHealth one-time deductible billing. At the request of the patient, the health center may bill a low-income patient in order to Allow the patient to meet the required CommonHealth one-time deductible as described in 130 CMR 506.009. *613.08(3) (f)*

6.9 Medical Hardship Patient & Emergency Bad Debt Eligible for Medical Hardship: The Health center will not undertake a Collection Action against an individual who has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution. *613.08(3) (g).*

6.10 Provider Fails to Timely Submit Medical Hardship Application

The health center will not undertake a collection action against any individual who has qualified for Medical Hardship with respect to any bills that would have been eligible for HSN payment in the event that the health center has not submitted the patient's Medical Hardship documentation within 5 days. *613.05(2).*

7. Minimum Collection Action on Hospital Emergency Bad Debt & CHC Bad Debt *613.06(1)(2)(3) and (4)*

The Health center makes the same effort to collect accounts for Uninsured Patients as it does to collect accounts from any other patient classifications.

Any collection agency used by the health center is required to conform to the above policies.

The minimum requirements before writing off an account to the Health Safety Net include:

7.1 Initial Bill: The health center sends an initial bill to the patient or to the party responsible for the patient's personal financial obligations. *613.06(1)(a)3bi*

7.2 Collection action subsequent to Initial Bill: The health center will use subsequent bills, phone calls, collection letters, personal contact notices, and any other notification methods that constitute a genuine effort to contact the party responsible for the bill. *613.06(J)(a)3bii*

7.3 Documentation of alternative collection action efforts: The health center will document alternative efforts to locate the party responsible or the correct address on any bills returned by the USPS as "incorrect address" or "undeliverable." *613.06(J)(a)3biii*

7.4 Final Notice by Certified Mail: The health center will send a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable" *613.06(J)(a)3biv*

7.5 Continuous Collection Action with no gap exceeding 120 days: The health center will document that the required collection action has been undertaken on a regular basis and , to the extent possible, does not allow a gap in this action greater than 120 days. If, after reasonable attempts to collect a bill, the debt for an Uninsured Patient remains unpaid for more than 120 days, the health center may deem the bill to be uncollectible and bill it to the Health Safety Net Office. *613.06(l) (a) 3bv*

7.6 *6 Collection Action File* The health center maintains a patient file which includes documentation of the collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made. *613.06(J)(a)3d*

7.7 Emergency Bad Debt Claim and EVS Check – NA

7.8 HLHC Bad Debt Claim and EVS Check – NA

7.9 CHC Bad Debt Claim and EVS Check. The health center may submit a claim for Urgent Care Bad Debt for Urgent Care Services if:

(a) The services were provided to:

1. An uninsured individual who is not a Low Income Patient. The health center will not submit a claim for a deductible or the coinsurance portion of a claim for which an insured patient is responsible. The health center will not submit a claim unless it has checked the REVS system to determine if the patient has filed an application for MassHealth; or

2. An uninsured individual whom the health center assists in completing a MassHealth application and who is subsequently determined into a category exempt from collection action. In this case, the above collection actions will not be required in order to file.

(b) The Health center provided Urgent Services as defined in 101 CMR 613.02 to the patient. The Health center may submit a claim for all Eligible Services provided during the Urgent Care visit, including ancillary services provided on site.

(c) The responsible provider determined that the patient required Urgent Services. The health center will submit a claim only for urgent care services provided during the visit.

(d) The Health center undertook the required Collection Action as defined in 101 CMR 613.06(1)(a) and submitted the information required in 101 CMR 613.06(1)(b) for the account; and

(e) The bill remains unpaid after a period of 120 days. 613-06(4)

8. Available Third Party Resources *613.03(J)(c)3*

8.1 Diligent efforts to identify & obtain payment from all liable parties: The health center will make diligent efforts to identify and obtain payment from all liable parties. *613.03(J)(c)3*

8.2 Determining the existence of insurance, including when applicable motor vehicle liability:

In the event that a patient seeks care for an injury, the health center will inquire as to whether the injury was the result of a motor vehicle accident; and if so, whether the patient or the owner of the other motor vehicle had a liability policy. The health center will retain evidence of efforts to obtain third policy payer information. *613.03(l) (c) 3a*

8.3 Verification of patient's other health insurance coverage: At the time of application, and when presenting for visits, patients will be asked whether they have private insurance. The health center will verify, through EVS, or any other health insurance resource available to the health center, on each date of service and at the time of billing. *613.03(1)(c)3b*

8.4 Submission of claims to all insurers: In the event that a patient has identified that they have private insurance, the health center will make reasonable efforts to obtain sufficient information to file claims with that insurer; and file such claims. *613.03(l)(c)3c*

8.5 Compliance with insurer's billing and authorization requirements: The health center will comply with the insurer's billing and authorization requirements. *613.03(J) (c) 3d*

8.6 Appeal of denied claim. The health center will appeal denied claims when the stated purpose of the denial does not appear to support the denial. *613.03(J)(c)3e*

8.7 Return of HSN payments upon availability of 3rd_party resource: For motor vehicle accidents and all other recoveries on claims previously billed to the Health Safety Net, the health center will promptly report the recovery to the HSN. *613.03(1){c)3f*

9. Serious Reportable Events (SRE) *613.03(1)(d)*

9.1 Billing & collection for services provided as a result of SRE: The heath center will not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 130.332 for services provided as a result of a SRE occurring on premises covered by a provider's license, if the provider determines that the SRE was: a. Preventable; b. Within the provider's control and c. Unambiguously the result of a system failure as required by 105 CMR 130.332 (B) and (c). *613.03(1) (d) 1*

9.2 Billing & collection for services that cause or remedy SRE: The health center will not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 120.332 for services directly related to: a. the occurrence of the SRE; b. The correction on or remediation of the event; or c. Subsequent complications arising from the event as determined by the Health Safety Net office on a case-by-case basis. *613.03(1)(d)2*

9.3 Billing and collection by provider not associated with SRE for SRE-related services: The health center will submit claims for services it provides that result from an SRE that did not occur on its premises *613.03(I)(d)3*

9.4 Billing & collection for readmission or follow-up on SRE associated with provider: Follow-up Care provided by the health center is not billable if the services are associated with the SRE as described above. *613.03(1) (d) 4*

10. Provider responsibilities *613.08(1)(a)(b) & (h)*

10.1 Non-discrimination: The health center shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status. *613.08(1)(a)*

10.2 Board Approval Before seeking legal execution against patient home or motor vehicle. . Before seeking legal execution against a low-income patient's home or motor vehicle, the health center requires its Board of Directors to approve such action on an individual basis. *613.08(1) (b)*

10.3 Advise patient on TPL duties and responsibilities: The health center will advise patients of the responsibilities described in 10J CMR 613.08(2) at the time of application and at subsequent visits. *613.08(J)(h)*

11. Patient Rights and Responsibilities *613.08(1)(2)*

11.1 Provider Responsibility to advise patient on right to apply for MassHealth, Health Connector Programs, HSN, and Medical Hardship: The health center informs all patients of their right to apply for MassHealth, Health Connector Programs, HSN, and Medical Hardship. *613.08(2)(a)1*

11.2 Provider responsibility to provide individual notice of eligible services and programs of public assistance during the patient's initial registration with the provider. The health center informs all Low Income Patients and patients determined eligible for Medical Hardship of their right to a payment plan as described in 101 CMR 613.08(1)(f). *613 08(1)(e)2a [change*

11.3 Provider responsibility to provide individual notice of eligible services and programs of public assistance when a provider becomes aware of a change in the patient's eligibility for health insurance coverage: The health center provides patients with individual notices of eligible services and programs of public assistance when we become aware of a change in the patient's eligibility for health insurance coverage. *613.08(1)(e)2c*

11.4 Provider responsibility to advise patient of the right to a payment plan: The health center advises patients of their right to an payment plan. 613.08(2)(a)2

11.5 Provider responsibility to advise patient on duty to provide all required documentation: The health center advises patients of their duty to provide all required documentation. *613.08(2)(b)1*

11.6 Provider responsibility to advise patient of duty to inform of change in eligibility status and available third party liability (TPL): The health center informs all patients that they have a responsibility to inform the health center and/or MassHealth when there has been a change in their MassHealth MAGI Household income or Medical Hardship Family Countable Income as described in 101 CMR 613.04(1), insurance coverage, insurance recoveries, and/or TPL status. *613.08(2) (b) 2*

11.7 *Provider responsibility to* advise patient on duty to track patient deductible: At the time of application, Low Income Partial patients are advised that it is their responsibility to track expenses toward their deductible and provide documentation to the health center that the deductible has been reached when more than one family member has been determined to be a Low Income Patient or if the patient or family members receive Eligible Services from more than one provider. *613.08(2)(b)3*

11.8 Provider responsibility to inform the HSN Office or MassHealth of a TPL claim/lawsuit: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient of his/her duty to inform the HSN Office or MassHealth of a TPL claim/lawsuit as well as to: *613.08(2)(b)4*

11.9 Provider responsibility to advise patient on duty to file TPL claims on accident, injury of loss: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient of his/her duty to file TPL *claims.613.08 (2) (b) 4a.*

11.10 Provider responsibility to inform patient on Assigning the right to recover HSN payments from TPL claim proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center informs the patient that they are required to assign the right to recover HSN payments from the TPL proceeds. *613.08(2) (b) 4bi*

11.11 Provider responsibility to inform patient to provide TPL claim or legal proceedings information: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the healthe center informs the patient that they are required to provide TPL claims or legal proceedings information. *613.08(2) (b) 4bii*

11.12 Provider responsibility advise patient to notify HSN/MassHealth within 10 days of filing a TPL claim/lawsuit: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a

lawsuit or insurance claim, the health center advises the patient that they are responsible to notify HSN/MassHealth of it within 10 days. *613.08(2)(b)4biii*

11.13 3 Provider responsibility to advise patient of duty to repay the HSN for applicable services from TPL Proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that they are responsible for repaying the HSN for applicable services from TPL proceeds. *613.08(2)(b)4biv*

11.14 Provider responsibility to provide individual notice of financial assistance during the patient's initial registration with the provider: The health center provides individual notice of financial assistance during the patient's initial registration. 613.08(1)(e)1 a

11.15 Provider's responsibility to provide individual notice of financial assistance when the provider becomes aware of a change in a patient's eligibility or health insurance coverage: The health center provides individual notice of financial assistance when the provider becomes aware of a change in a patient's eligibility or health insurance coverage. *613.08(J)(e)1c*

11.16 Provider responsibility to advise patient of HSN limit on recovery of TPL claim proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that recovery from TPL payments is limited to the HSN expenditures for eligible services. *613.08(2)(c)*

12. Signs *613.08(1) (/)*

12.1 Location of the signs The Health center has posted signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance programs and the health center location at which to apply for such programs. *613.08(1)(/)1*

12.2 Size of the Signs: The signs are large enough to be clearly visible and legible by patients visiting these areas. *613.08(1)(/)1*

12.3 Multi-lingual signs when applicable: All signs and notices have been translated into the languages spoken by 10% or more of the residents in our health center's service area. These are: English *613.08(1)(/)1*

12.4 Wording in Signs: The health center signs notify patients of the availability of financial assistance and of programs of financial assistance. *613.08(1)(/)1*

"If you are unable to pay this bill, financial assistance is available. Please call 617-376-3000 for further information."

12.5 Providers must make their Credit & Collection Policy and provider affiliate list, if applicable, available on the provider 's website. 613.08(1)(/)2

www.manetchc.org

13. Sample Documents & Notices on Availability of Assistance *613.08(1)e) & (/)*

13.1 Sample of Assistance Notice on Billing Invoice Attached *613.08(1)(e)1b*

13.2 Sample of Eligible Services and programs of assistance – notice on billing invoice.- Attached *613.08(J)(e)2b [attach}*

13.3 Sample of Assistance notice in collection actions (billing invoices) – Attached *613.08 (J) (e) 3*

13.4 Sample of Payment plan notice to Low Income or Medical Hardship patients – Attached *613.08(J)(e)4*

13.5 Sample of Posted Signs -attached *613.08(1)(f)*

Authorized Signature: *Gail Covelluzzi*
Title: CFO

MANET COMMUNITY HEALTH CENTER INC.

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Pdlienl Accountt
It
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Your Account Status

Your health insurance has been billed correctly and the remaining deductible is your responsibility. Your balance is past due

Payment Due
$149.13
Due Upon Receipt

Choose a Payment Method

Pay Online
Recommended

Make a secure online payment: www.quickpayportal.com
QuickPay Code: 5669-W935-S411-5VM

Mail Payment

Mail your payment with the coupon below.
Make checks payable to: MANET COMMUNITY HEALTH CENTER INC..
Please include your account # on the check.

Questions? Have a question about your balance, or need to update your insurance information with us? Call 617-376-3000

Q Thank you for choosing MANET COMMUNITY HEALTH CENTER INC.

Unable to pay you may qualify for financial assistance
Call 617-376-3000

p Enjoy the ease and security of paperless statements. Visit the Patient Portal today to sign up.

detailed summary >

Detach this coupon and return with your payment

MANET COMMUNITY HEALTH CENTER INC.
PO BOX 14099
BELFAST ME 04915

Pay Online At QuickPay
www.qulckpyportal.com IQulckPay Code: 5669W935 S415VM

Due Date	Patient Account #
Upon Receipt	
Amount Due	**Amount Enclosed**
$149.13	

Make checks payable to MANET COMMUNITY HEALTH CENTER INC..
Pease include your account # on the check.

MANET COMMUNITY HEALTH CENTER INC.
BELFAST ME 04915-4033
ATTN# 11023Y
PO BOX 14000

O Check box if insurance or patient information has changed.

Please indicate change on reverse side.

FREQUENTLY ASKED QUESTIONS

Your Statement

Why am I receiving this statement?
You are receiving this statement because either you or a dependent received services from a provider in our medical group. Services from providers that are not affiliated with our medical group are not included.

Why am I getting a bill from a provider whom I didn't see?
You may not meet all providers who assist with your care. For example, you may not have met the physician who supervises the nurse practitioner that assessed you, or the pathologist who reviewed your lab results.

Your Balance

Why don't I see my previous payment in this statement?
This statement includes only the outstanding charges on your account. If your previous payment was towards a charge that is no longer outstanding, you will see your previous payment and the closed charge on the first statement that is sent after the payment is processed, but not on subsequent statements.

Was my insurance billed and did they pay correctly?
If your insurance information was on file with our office, this statement reflects the contributions from your insurer. You should receive an explanation of benefits from your insurer explaining the remaining balance. Please contact your insurer if you have questions about your insurance eligibility, coordination of benefits, or why a service was not covered.

What do Copay, Deductible, Coinsurance, and Misc. next to my outstanding balances mean?
These terms indicate why you owe a balance and are related to your insurance coverage.

- **Copay** - the set amount you must pay for a health care service.
- **Deductible** - the amount you must pay for health care before your insurance benefits take effect.
- **Coinsurance** - the percentage of health care costs you must pay once your insurer covers its share. Coinsurance typically goes into effect once the deductible has been reached.
- **Misc.** - refers to other reasons you may owe a balance, such as a service not being covered by your insurer.

Why am I being billed twice for the same service?
If you received care in a hospital setting or clinic, you may be billed for both professional and facility fees, and you may see two charges for the same service. Professional fees are related to the lime your caregiver spends treating you during your visit. Facility fees are for the use of the healthcare facility, equipment, supplies, and staff supporting your provider.

Making a Payment

How do I make a payment?
Please see the reverse side of this statement for more information about payment methods.

What if I can't pay my balance?
If you are unable to pay your balance, please contact our office as soon as possible so that we can discuss payment arrangements with you1

If your information has changed, please indicate changes below and check the box on the reverse side of this page,

Patient Information

Your Name (last, First, Middle Initial) Dato of Birth

Address

City State Zip

Telephone

( )

Social Security /i

Employeis Name Telephone

Employer's Address

City Stale Zip

Pleasehdtate 11 Applicatle: Date of Injury

0AUTO ACCDENT

11WORKER'S COMPENSATION

Insurance Information

Your PRIMARY Insurance Company's Name

Primary Insurance Company's Address

City State Zip

Policyholder Name Date of Birth Sex

Policyholder's ID Number Group Plan Number

Yom SECONDARY Insurance Company's Name

Secondary Insurance Company's Address

City State Zip

Policyholder Name Date of Birth Sex

Policyholder's ID Number Group Plan Number

Manet Community Health Center

12/5/14

Discount Fee Policy

Manet charges the usual and customary prevaihg rate for health care services rendered. Yet, Manet will not discriminate against any persons due to financial class or payment methods for services received.

We have several options available to include discounts based on household income and size. A sliding fee schedule is used to calculate the discount and is updated each year using the federal poverty guidelines. Once approved the discount is valid for 1 year plus the 3 prior months. For example, if you are approved December 1, 2014 coverage begins September 1, 2014

You must apply annually.

Please see a Navigator for application assistance.