CENTRAL VALLEY MEDICAL CENTER
NEPHI, UTAH
Credit and Collection Policy

It is the purpose of Central Valley Medical Center to provide quality care for the community of Nephi and our surrounding area. We believe the maintenance of this medical center can best be attained within the framework of sound fiscal management. The following policy states the basic requirements of Central Valley Medical Center's credit and collection effort.

All patients possessing orders from a staff physician will be admitted regardless of their ability to pay. Central Valley Medical Center will provide, without discrimination, care for emergency medical conditions within the meaning of the Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act to individuals regardless of their eligibility under the medical center's Financial Assistance Program.

Insurance

Services rendered are charged to the patient, not to an insurance company. The patient is responsible for all charges, regardless of the insurance coverage. The filing of claims with the insurance companies in no way relieves the patient from his or her obligation.

Insurance benefits will be assigned to Central Valley Medical Center at the time of treatment. Policy co-pays, deductibles, and/or co-insurance will be paid at the time of service. Information relative to all types of health insurance the patient may have must be presented prior to or upon treatment.

Patients without Insurance

For those unable to pay cash at the time of discharge, arrangement must be made with the Business Office. Charges incurred by patients without insurance coverage will be due based on the payment schedule. Financial Assistance Policy and Application form will be available to patients upon request and available from the web-site.

Inpatient Services

Patients with requirements from the insurance carrier for pre-admission certification are required to contact their insurance carrier and to advise the hospital Business Office at the time of admission. If a patient is expecting to be admitted to the hospital at some point in the future, they must complete the pre-admission form as soon as the patient knows about the upcoming admission.

If a patient fails to notify the hospital of pre-admission certification needs, any increases in deductible/coinsurance from the insurance carrier will be the patient's responsibility. Any remaining balance from inpatient services is due based on the payment schedule.

Emergency Services

Patient insurance will be billed for emergency services if the information is provided at the time of service. Any remaining balance from emergency services is due based on the payment schedule.

Outpatient Services

Patient deductible/co-insurance will be paid to services rendered or payment arrangements established based on the payment schedule. Patients with requirements from the insurance carrier for pre-admission certification for outpatient procedures are required to contact their insurance carrier and to advise the

hospital Business Office prior to admission. If a patient fails to notify the hospital of pre-admission certification needs, any increases in deductible/co-insurance from the insurance carrier will be the patient's responsibility.

Medicare

Patients must present proper Medicare identification and supplemental insurance cards at time of service. Supplemental insurance will be filed after Medicare payment has been received. The patient is responsible for items listed as non-covered under Medicare contract for which an Advanced Beneficiary Notice (ABN) has been signed and deductible and/or co-insurance not covered by supplemental insurance. Remaining balance is due based on the payment schedule.

Medicaid

Patients are required to present the current Medicaid identification card at the time of service. If the patient has other insurance coverage, Medicaid will be billed as supplemental insurance. Any co-pays are due at the time of service. Remaining balance including cost share and non-covered services will be based on the payment schedule.

VA

VA patients must have prior authorization from the VA for all hospital services. VA has defined some emergencies which are excluded from the prior authorization requirement. Authorization for services is the patient's responsibility.

Auto Accidents & Workers Compensation

Most health insurance companies now exclude payment for any benefits which might be covered by auto insurance, worker's compensation, or any other liability coverage. If any injury is the result of an auto accident, work place accident or other accident where other liability coverage might exist, please notify the Business Office of Central Valley Medical Center at the time of treatment so the appropriate billing action can be taken. The patient is responsible for the bill even if there may be a potential liability action.

Payment Schedule for Accounts

The following payment schedule is available for any account at Central Valley Medical Center:

- Monthly payments that will result in reducing the balance to $0 over a period of 6 months.
- Monthly payments to a payment management company that will result in reducing the balance to $0 over a period of more than 6 months.

If an account on a payment schedule becomes more than 90 days delinquent, a final notice will be issued and the account may be sent to a collection agency if payment is not satisfied. Central Valley Medical Center accepts Visa, MasterCard, Discover, and American Express credit cards.

Collection Report

- In-house contact will be established with each patient or account guarantor to insure a complete file of payer information is available and thus insure prompt payment.

- Telephone and written contact will be attempted with a guarantor of a delinquent account. All calls must comply with current federal and state regulations regarding collection practices.

- Bad debts will be listed with an appropriate collection agency when approved by the Revenue Cycle Director.

- An account is considered delinquent 10 days prior to being turned over to a collection agency. An account is in default once it is turned over to the agency.

- Collection agencies will be monitored on an annual basis.

- When approved by the Revenue Cycle Director, legal action will be initiated by the hospital as necessary to collect receivables or to recover bad debts.

Itemized Statements

Attorneys, Insurance Representatives and Insurance Claims Adjustors may be provided with an itemized statement when the request is accompanied by a written authorization which has been signed by the account guarantor and whose date is within 60 days of the request date.

Procedure for the Filing of Creditor's Claims and Estates

If an account is discovered in-house to be owed by an estate, a claim will be filed by the Revenue Cycle Director against all estates upon receipt of a Notice to Creditors. Such notices are normally obtained from a newspaper clipping. The following steps are to be taken in each case:

- Complete a Proof of Claim form by entering data pertinent to the estate in question. The patient's accounts should be listed to show estate as guarantor. (e.g., Smith Estate).

- Prepare a transmittal letter by entering the appropriate information.

- Make copies of both the completed claim form and the completed transmittal letter to the appropriate clerk of court by certified mail.

- Attach the certified mail receipt to the claim copies when it is returned by the post office.

- Retain all materials in the Creditor's Claim file until the account balance is paid. After payment, all materials should be stored and preserved as required by existing retention policies.

Disputed Claims

Any dispute regarding the cost of hospital services will be referred to the Revenue Cycle Director. All settlements will be approved by the Revenue Cycle Director in keeping with the Medical Center's policies. All patient care disputes are forwarded to Risk Management. If necessary, disputed claims will be referred to the President/CEO and/or Hospital Attorney.

Refunds

Refund payments to individuals will be made only after settlement of all previous bad debt accounts and active accounts.