SONORAN ORTHOPAEDIC
TRAUMA SURGEONS

Medical Financial Hardship

Policy:
Sonoran Orthopaedic Trauma Surgeons, P.L.L.C. has established this policy in an order to maintain consistency in assisting uninsured, indigent and those patients with substantial financial issues who request a reduction or waiver of certain medical charges.

Co-payments, deductibles, or other owed amounts that are the patient's responsibility under the rules of the Medicare, Medicaid or any other governmental or commercial third-party payer may not be waived, except on a case by case basis upon a determination of financial need. Routine waiver of co-payment, deductible, or other owed amounts may be a violation of federal law and is a violation of Sonoran Orthopaedic Trauma Surgeons policy.

Documentation:
You will be required to provide documentation to Sonoran Orthopaedic Trauma Surgeons in order to assist us in determining a decision regarding reduction or waive of charges owed for services provided by Sonoran Orthopaedic Trauma Surgeons.

- ☐ W-2 withholding statements or Unemployment check stubs for the past 90 days.
- ☐ Pay check stubs for the past 90 days for all persons employed in the home.
- ☐ Proof of all other income received in the past 90 days.
- ☐ Proof of all outstanding debts or bills (copies of bills, statements, late notices).
- ☐ Proof of Bankruptcy settlement (if applicable).
- ☐ Other (Please describe other circumstances):

_____

_____

If approved, Sonoran Orthopaedic Trauma Surgeons may elect to reduce or waive certain amounts which are due from the Patient and/or guardian/guarantor who can successfully demonstrate that paying these medical charges would cause significant financial hardship.

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Financial Hardship Application

Name: _____ Phone #: _____

Address: _____ Date of Birth: _____

City, State, Zip: _____

1.) Are you receiving any type of assistance from local, county, state or federal government agencies? If yes, what types of assistance are you qualified to receive?

_____

2.) If not, do you qualify for assistance from local, county, state or federal government agencies? If so, what types of assistance are you qualified to receive?

_____

3.) Do you have other health insurance that covers health related products or services?

☐ Yes ☐ No * If "Yes", list the companies and policy numbers:

_____

_____

4.) Is a guardian or anyone else legally responsible for your medical bills?

☐ Yes ☐ No * If "Yes", give name, address and phone numbers of this person:

_____

_____

5.) Are you employed?

☐ Yes ☐ No * If "Yes", please provide employer's name, address and phone number:

_____

_____

What is your pay period? ☐ Weekly ☐ Bi-weekly ☐ 1st & 15th ☐ Other: _____

What is your Gross per pay period? _____

What is your Net per pay period? _____

Medical Financial Hardship

6.) Do you own your home? ☐ Yes ☐ No

Are you still making payments on it? ☐ Yes ☐ No Monthly payments are: _____

7.) How much do you have in Savings to which you have immediate access? _____

8.) What are your Monthly Net income from?

Your Employment: _____

Social Security: _____

Retirement _____

Investments: _____

Other: _____

Total Monthly Income: _____

9.) What are your Monthly Expenses:

Rent/House payment: _____

Utilities: _____

Car payment: _____

Other Transportation: _____

Food: _____

Medical bills: _____

Other: _____

Total Monthly Expenses: _____

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I certify that the above information is true and correct. I request that you consider me for reduction or waiver of charges/balance.

Signature _____ Date _____

Signature of representative if patient is unable to sign _____ Relationship to Patient _____

Reason patient is unable to sign _____

FOR OFFICE USE ONLY

Reduction of Charges/Balance

☐ Approved ☐ Denied

% of Reduction: _____

Reduction in effect for date(s) ONLY: _____

Waiver of Charges/Balance

☐ Approved ☐ Denied

Amount Waived $ _____

Waiver in effect for date(s) ONLY: _____

Signature _____ Date _____

Title _____