PHILIP HEALTH SERVICES, INC.
Patient Financial Services
Account Collection Policy

Purpose

To ensure patient accounts are billed accurately and timely, Philip Health Services will communicate account balances with all payers (all third party payers including Medicare & Medicaid, patients and/or responsible parties). All patient accounts will be billed in a consumer-friendly manner that consolidates or coordinates communication and payment.

Policy

The following patient account collection plan is to be used for receiving payments of services provided by Philip Health Services.

Definitions:

Co-payment (co-pay) is a capped contribution defined in the patient's policy and paid by an insured person each time a medical service is provided. It is usually paid before any policy benefit is payable.

Co-insurance is expressed as a percentage or pair of percentages generally with the insurer's portion stated first. Co-insurance indicates how an insurer and an insured will share the costs of a bill that exceeds the insurance policy's deductible up to the policy's stop loss. Once the insured's out-of-pocket expenses equal the stop loss the insurer may assume responsibility for 100% of any additional costs. This does not include the co-insurance for ancillary services (i.e., Lab, X-ray) related to private pay portions that Medicaid has established for Hospital or Nursing Home services.

Private Pay individuals pay for services out of pocket at the time of service for out-patient or inpatient Hospital procedures or for long-term care services. Long-term care and assisted living services do not qualify for the Philip Health Services financial assistance program.

Procedure:

1. Payment is due at the time of service, unless prior arrangements are agreed upon.
2. Third Party Carriers (Including IHS Eligible Patients):
    a. Philip Health Services will bill insurance/third party carriers in a timely and efficient manner.
    b. Collection activities are based upon the primary insurance of the account. Patients are responsible for providing the Business Office with accurate insurance information. This is necessary to bill amounts due to third party carriers or applying for state or federal program eligibility (Medicare or Medicaid)

c. Patient Accounts Representative(s) will monitor the payment activity of insurance/third party payers. If payment is not received within 30 days the Representative will contact the third party payer by phone or letter to determine the status of the account and appropriate action will be taken to resolve payment from the payer. If the account qualifies for automatic transfer to self-pay status, due to non-payment from the third party payer and collection efforts are continuing to be active with the payer, the Facility should maintain accounts in insurance status for 60 days so that the account will not be placed in self-pay status.
d. Upon receipt of payment from an insurance/third party payer, the remaining balance will be moved to the secondary insurance payer if applicable and a corresponding claim will be filed. If no secondary insurance exists on the account, the balance will be moved to self-pay status.

3. Collection Follow-Up Insurance/Third Party Payer (Including IHS Eligible Patients):
    a. Work list, compiled and produced by the Business Office will be worked 30-45 days from date of submission. Business Office Representatives will place call(s) to insurance companies to follow up on the status of claim. If unable to contact by phone, a follow-up letter will be mailed to the insurance company.
    b. A follow-up letter will be sent to the patient if no response is received 30 days from notice to insurance company. Patient is sent an information letter or contacted via telephone indicating that payment has not been received from their insurance carrier. Responsible party is asked to forward any correspondence from the insurance / third party payer company to help expedite payment.
    c. At 45 days research is begun to see why the payment was not made. If insurance / or third party payer has denied payment the balance is transferred to self-pay.
4. Self-Pay Accounts / Balances:
    a. The guarantor's portion of the bill is due and payable at the time the account is determined to be self-pay. All verified co-payments, co-insurances and deductibles are due at the time of service. If payment in full is not possible, financial arrangements will be made in accordance to the guidelines below.
    b. Monthly statements will be sent to the Guarantor identifying the balance due on account(s). The first billing will be sent within 20 days of the initial visit for Private Pay patients or within 20 days after the primary and secondary insurance companies have paid. Subsequent statements will be sent on a monthly basis at a minimum of 30-day cycles.
    c. Statements will contain information necessary for paying the account by credit card as well as information on how to contact the Business Office.
    d. Accounts having infrequent or small payments not meeting the payment schedule and without proper payment arrangements will be referred for further collection activity.
5. Failure to meet collection guidelines will result in account being referred to a third party collection agency. Account will be in "Bad Debt" Status while placed with a third party collection agency.
    a. At 90 days, a Bad Debt report is run which shows guarantors who have not made a payment for those past 90 days. The patient or guarantor is contacted and research is begun to see why the payment was not made.

b. After 90 days, the patient is contacted by the business office by phone and then within 5 days the creditor will send the debtor a copy of the debts that they are trying to collect. After 30 days from the initial call the debt will be sent to a third party collection agency unless other arrangements have been made. Collections List will be presented to the CEO for approval prior to submission to our third party collections agency.

6. Payment Schedule
    a. Patients / guarantors have 2 options available to pay the self–pay portion, which includes (uninsured, co-insurance, deductibles and non-covered services,) of the account balance due. Co-payments are excluded.
        - Option 1: Payment-in-full within 30 days' notice of a self-pay balance
        - Option 2: Patients/guarantors who are unable to remit payment-in-full in accordance with Option 1 may remit the balance due in installments based on the following self-pay balance.
            - Self-pay balance of $000.00 - $100.00 – 2 installments
            - Self-pay balance of $100.01 - $2000.00 – 5 installments
            - Self-pay balance of $2000.01 – and greater – 12 installments
            - Special considerations can be brought to the CEO's attention either in writing, email, or phone call.
        - The first payment must be received within 30 days of receiving notification of the self-pay balance due. Failure to do so will result in the account being placed into internal collection status for additional collection activity, not to exceed 90 days. Failure to meet collection guidelines will result in account being referred to a third party collection agency. Account will be in "Bad Debt" Status while placed with a third party collection agency.
        - Guarantors who demonstrate a financial inability to remit the balance due on the account and/or demonstrate financial difficulty in meeting a minimum monthly payment schedule will be provided with a Financial Assistance Application. See the Philip Health Services Financial Assistance Policy.
        - No extraordinary collection actions will be taken until the financial assistance policy timelines have been met.
        - Patients/guarantors who fail to commit to one of the 2 options above or fail to participate or qualify for the Financial Assistance Program will be placed with a third party collection agency for collection of the outstanding debt.
7. Third Party Collection Agency Standards:
    a. Agencies must abide by Philip Health Services collection policy.
    b. Agencies must understand the importance of patient service in the healthcare industry and must be able to deliver patient-sensitive service that respects the patient's rights and maintains patient dignity.
    c. Agencies will follow proven procedures and proper telephone techniques for effectively communicating with patients; talking, listening, responding to objections, while being

assertive and persuasive. Customer relations must be of highest importance. Philip Health Services will investigate/remediate customer service complaints.

d. Agencies may pursue legal judgment or lawsuit on accounts whose assets/income are worthy of such pursuit. Administrator or designee must approve all legal requests.
e. Collection agencies will refrain from abusive collection practices. Collection agencies are not permitted to place judgment against the primary residence of the patient / guarantor, are not permitted to place body attachments, nor are they permitted to threaten any action or verbalize any threat which is in direct contradiction to the mission of Philip Health Services.