PO Box 9032
2800 Beaumont Avenue
Liberty, TX 77575
936-334-9701

Dear Patient,

You have requested a discount/payment plan application regarding your ambulance services &/or ambulance transport.

Please review the attached page carefully. Complete all applicable areas on the application and be sure to include any ***required*** documentation – applications submitted without proper documentation are automatically disqualified for any financial consideration. To assist in your request, we have also enclosed a postage-paid, self-addressed envelope.

Once your application is received & reviewed, notations will be made in your account and a letter will be sent to the address identified on your application advising of the decision made.

Thank you,

Records Coordinator
Health Claims Plus

888-483-9893

PATIENT REQUEST FOR DISCOUNT or PAYMENT PLAN

Patient Name: _____ **Balance $**_____

Ambulance Provider: _____ **Pt Account #** _____

Our Client abides by the contractual and legal obligations of health benefit plans to collect all charges, co-pay, co-insurance, and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full, **Our Client** adopted the policy of screening requests for discounts, delayed payment plans, or forgiveness of debt based on individual circumstances. This form pertains to patients requesting a discount &/or payment plan. If you seek total financial hardship, please contact our office for a Patient Financial Hardship Application.

All information will be held confidential as per **Our Client's** privacy policy.

Patient Name:_____**DOB:**_____**SS#:** _____

Mailing address:

_____

Spouse Name:_____DOB:_____

Guarantor name(s):_____Date(s) of service: _____

*E-mail:_____Phone:_____

**By providing this information you give us permission to contact you via unencrypted format.*

Attach copy of Driver's License or identification card for all adults.

Type of Assistance Requested: *(Please check one)*

Reduced deductible [ ] Reduced co-pay/co-insurance [ ]
Discount of services [ ] Payment plan [ ]

Current Assistance being Received: *(Please check all that apply)*

State Financial Assistance [ ] Reduced co-pay/co-insurance [ ]
Food Stamps [ ] Payment plan [

Property/Investment : *(please check one)*

Residence [ ] Own [ ] Rent

I understand and acknowledge that by completing this form does not guarantee discount, payment plan, or forgiveness of debt. Likewise, if I am granted a discount &/or payment plan, said discount/payment plan only pertains to the date(s) of service listed on this form. Any future treatment &/or ambulance services from the Ambulance Provider listed on this form must be reviewed separately for discount/payment plan; each discount/payment plan is per episode.

Signature :_____Date: _____

REVERSE SIDE FOR OFFICE USE ONLY

PLEASE DO NOT WRITE BELOW. FOR OFFICE USE ONLY

Ambulance Provider: _____

Regarding Patient/Account#: _____

Received hardship letter from patient on:_____(Letter filed in eBridge System)

Approved for:

Discounted Amount - {list dollar amount or percentage} _____
[ ] Account granted discounted rate at or above Medicare Allowable Rate for same service level
[ ] Account granted other discount _____

If account Discounted, new Balance now reflects: $_____

Payment Plan granted - [ ] – First Payment due on: _____
Monthly Payment Amount: _____

Approved on:_____/_____/_____ By: _____

This page also serves as notice to Patient/Guarantor of Discount &/or Payment Plan determination. Any questions or concerns should be directed to:

HCP – Billing Office
2800 Beaumont Ave., Ste. E
Liberty, TX 77575
Attn: Patient Financial Services Dept. / Phone: 888-483-9893

Notes: