Ravalli Family Medicine Discount Fee Policy

If you have ANY type of insurance you do not qualify for this program

Policy

It is the policy of Ravalli Family Medicine to provide essential services regardless of the patient's ability to pay. Discounts are offered to uninsured individuals who are not qualified for federal assistance through Medicare/Medicaid. These discounts are calculated dependent upon the household income and size. A sliding fee schedule is used to calculate the basic discount and is updated each year using the federal poverty guidelines. Once approved, the discount will be honored for one year, after which the patient must reapply.

Discount Calculation

Discounts are based upon the total income of a person or family. The income is compared to the federal poverty guidelines, which change annually. Our discounts are as follows:

- Those persons/families that make 250% of the federal poverty level or above are not eligible for a discount.
- Those who are at the 200% level will receive a 25% discount
- Those who are at the 175% level will receive a 50% discount
- Those who are at the 133 and 138% level will receive a 75% discount
- Those who are at 100% federal poverty will be charged a nominal charge. That nominal charge is currently $20.00 regardless of services rendering.
- An example of the calculation in action follows:
  - One of the most common office visits, a Level 3 visit, has a rate of $109.20. If you are at the 175% level, you would be charged $54.60.
- Copies of the federal poverty guidelines are available. Please ask a member of our billing staff for this information.

Discount Application Process

A completed application including required documentation of the home address, household income and supporting papers must be on file and approved by the business office before a discount will be granted. If the applicant appears to be eligible for Medicaid, a written denial of coverage by Medicaid may also be required.

Adolescent patients seeking confidential care may be exempt from the application process. Each case will be decided individually.

You will be given an application today and will be required to pay our minimum fee of $20. Depending on what discount you are approved for you may owe more for today's visit.

You need to fill out application COMPLETELY with supporting documents and return as soon as possible (and before your next office visit).

You will be notified of approval by mail.

You will then be required to pay the discount fee at EVERY office visit. If you carry a balance and it is not paid then the discount will be reversed and you will be responsible for the entire charge and will not be able to make an appointment until undiscounted balance is paid in full.

Services Covered and Excluded

Medical: The discount applies to all office visits and does NOT apply to charges when admitted to Marcus Daly Memorial Hospital. Procedural charges will be discounted on a case by case basis and need to be discussed in advance of said procedure.

Lab and X-ray: Reference laboratory tests and Radiology charges are excluded. In house laboratory discounts will be dependent upon costs to this facility and need for continued care. Tests done upon request of the patient and not demeaned medically necessary may be charged at full cost.

Ravalli Family Medicine Patient Assistance Application

411 W Main, Hamilton MT 59840

Ph: 406-363-5104, Fax: 406-363-2894

Patient Name:

Phone Number:

Address:

City, State & Zip:

SSN: Date of Birth:

Place of Employment:

□ unemployed: length of unemployment _____

Spouse Name:

SSN: Date of Birth:

Place of Employment:

□ unemployed: length of unemployment _____

Dependents (under age 18): **Date of Birth**:

1._____

2._____

3._____

4._____

5._____

6._____

(Over)

Office Use Only

Given to Patient: Category Approved: Approved By:

Received from Patient: Effective Date: Expiration Date:

Annual Household Income: Please list how much you are making in each category.

Source **Please list amounts PER YEAR, IF OTHER (DAY, MOTNH, ETC) PLEASE SPECIFY!**	**Self**	**Spouse**	**Other**
Gross Wages, Salaries, Tips			
Social Security, Pension, Annuity, Veteran's Benefits			
Alimony, Child Support, Military Family Allotments			
Income from Business Self Employment			
Rent, Interest, Dividends and Other Income			
TOTAL YEARLY INCOME:			

Insurance: □ Yes □ No

PLEASE ATTACH THE FOLLOWING….

____ Identification (driver's license, social security card, or birth certificate)

____ Income (prior year tax return (not a W2) and three most recent pay stubs)

____ Medicaid (evidence of Rejection)

Please explain if any of these forms cannot be provided:

ALL SECTIONS OF THIS FORM AND ALL ATTACHMENTS ARE REQURED FOR QUALIFICATION. IMCOMPLETE APPLICATIONS OR MISSING ATTACHMENTS WILL CAUSE YOUR APPLICATION TO NOT BE PROCESSED. APPROVAL DATE FOR DISCOUNTS MAY BE MOVED.

I certify that the information shown is correct and understand verification is required for approval.

_____

Print Name Signature Date

_____

Spouse Name Signature Date