THE PAIUTE INDIAN TRIBE OF UTAH

440 North Paiute Drive • Cedar City, Utah 84721 • (435) 586-1112

COLLECTIONS POLICY AND PROCEDURE

September 2013

Policy: It is the policy of the Tribe to maximize on billing revenue so these funds can be used to support the operational cost of the Health Department.

A. Guideline. This policy applies to all patients accessing the Paiute Tribal Clinics. Payment in full is expected at the time of service when a balance is identified, or upon receipt of the first statement from the billing office when a balance is identified at a later date.

1. PITU clinics will bill insurance companies.
2. The PITU billing office expects payment for patient deductibles.
3. We require prompt and complete payment on account.
4. "No Show" charges are considered a collectible charge and may be sent to collections.
5. Payment agreements are a viable option for hardship cases. Examples;
   a. House in foreclosure
   b. Loss of income
   c. Extensive medical bills
6. No personal checks will be accepted, only cashier's checks or money orders will be accepted from individuals who are mailing in their payments.

B. Scope of Service.

1. Excessively late bills are those account balances over 120 days old.
2. The following procedures will be followed when collecting a self pay balance:
   a. Three consecutive monthly statements will be mailed to the client.
   b. The fourth month a reminder of balance due letter will be mailed (see attachment A)
   c. The fifth month a telephone call, reminding the client of their financial obligation.
3. Delinquent accounts will be reviewed for collections.

C. Bad Debt/Uncollectable Account Write-off

1. The CHS/Billing Supervisor will review all patient balances in excess of 120 days.
   a. Accounts will be reviewed monthly with the Patient Account Representative. The determinations for collections will be made at that time.
   b. The CHS/Billing Supervisor will sign off all accounts to be sent to collections.
2. Accounts 120 days past due that show no payment activity will be sent to an outside collection agency.
   a. The account balance will be written off to "bad dept".
   b. Account ledgers will be printed and forwarded to the collection agency.
   c. Patient demographic information will be forwarded to the collection agency.
   d. The account will be flagged as "cash only".
3. Small balances under $5.00 will be written off to "bad debt".
4. Notice of bankruptcy, when received will be forwarded to the collection agency.
5. If the Paiute Tribe is not listed on the court document, collections will proceed as usual.

D. Payment Arrangement Application Process.

1. A minimum of $25 or 10% of the balance will be due each month. (whichever is greater)
2. A payment agreement letter will be signed by the patient/guarantor. (attachment B)
3. If the balance increases, so does the minimum monthly amount due.

E. Use of Outside Agencies for Collection

1. The Paiute Tribe will contract with an outside collection agency to handle all delinquent accounts.
2. The client (and family) accounts sent to collections will be flagged as "cash only" (meaning we require them to pay up front for any future visits).
3. If the client has future accounts that go to collections, the client (and family) will be discharged from the practice. (see attachment C)

F. Compliance. If the above guidelines are not followed, the delinquent account will be turned over to the contracted collections agency.

Atachment A

SAMPLE WARNING LETTER

Dear Patient,

We are disappointed to be sending you this letter. You have not cooperated with the efforts of our billing staff to abide by our clinic's financial policies. We are preparing to send your account to our collection agency. If your account is sent to collection or if you declare bankruptcy, here is what to expect:

At future appointments, you will be expected to pay your portion of charges in full. We will refund to you any money later paid by insurance in excess of what you owe us or forward the money to pay any collection agency balance. If you are on Medicaid and you do not bring us a current copy of your card at the time of service, you will be expected to pay for the service in full. This payment status is in effect for one year from the date of this letter or until collection balances are paid, whichever is longer.

If we must send your account to our collection agency again, you will be dismissed from our practice. We will no longer provide your medical care.

This policy applies to you and all members of your immediate family.

If you have questions or information that may help us manage your account, please call our billing department as soon as possible.

Sincerely,

Billing Department

Attachment B

PATIENT PAYMENT APPLICATION

Our practice abides by the contractual and legal obligations of health benefit plans to collect charges and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full at the time of service, we have adopted a policy of screening requests for delayed payment plans. To do this, we must ask for certain financial information. *All information will be held confidential according to our privacy policy.* Please provide the documents listed below for each adult family member, and complete this form to the best of your ability:

- A copy of last year's federal tax return;
- Copies of the two most recent payroll stubs or unemployment benefit payments;
- If income is close to or below the poverty level, documentation that state medical assistance has been applied for and denied.

Patient name: _____ Patient date of birth: _____

Your name: _____ Name of other responsible party: _____

Number of dependents in household: _ Number in school: _____

Phone: _____

E-mail: _____

Employment/unemployment information (for each adult family member)

Name: _____ Employer: _____

Address: _____

Phone: _____

Employer: _____

Address: _____

Phone: _____

Name: _____ Employer: _____

Address: _____

Phone: _____

Employer: _____

Address: _____

Phone: _____

If unemployed, please state when employment was terminated. If lay-off is temporary, indicate expected duration:

Notes:

By my signature below, I certify that this information is true and complete. I grant this office permission to verify the information, and I acknowledge that completion of this form does not guarantee discount, payment plan or forgiveness of debt.

Signed: _____ _____ Date: _____

Reviewed by: _____ ____ Date: _____

Account Balance: $_____

Approved for: $_____per month

Attachment C

SAMPLE DISMISSAL LETTER

Dear Patient,

As you know, we have been unsuccessful in our attempts to resolve the outstanding balance on your account. We previously informed you that our practice would withdraw as your provider of medical care unless you made an effort to cooperate with our financial policies. We now have been forced to send your account to our collection agency for yet another time. As a result, we have decided to stop providing medical care to you and members of your immediate family.

We recommend that you find another provider of medical care. You may call your local hospital for assistance. Our office will transfer your records to another medical office upon receipt of your written request. Meanwhile, our clinic will be available to treat you for emergencies only for the next 30 days. Please call our billing department if you have any questions regarding this action.

Respectfully,

Your Physician

CERTIFICATION

I heareby certify that the foregoing Collections Policy and Procedure was full considered and adopted by the Health Commitee at a duly called meeting in Cedar City, Utah, at which a quorum was present, and that the same was passed by a vote of 4 in favor, 0 opposed, 1 absent, and 0 abstained, this 15 day of October , 2013

Laurel Yellowhorse, Health Committee Chairwomen

ATTEST:

Laurel Yellowhorse, Administrative Assistant

CERTIFICATION

I heareby certify that the foregoing Collections Policy and Procedure was full considered and adopted by the Health Commitee at a duly called meeting in Cedar City, Utah, at which a quorum was present, and that the same was passed by a vote of 5 in favor, 0 opposed, 0 absent, and 0 abstained, this 1st day of November , 2013

Gari Lafferty, Tribal Chairwomen

ATTEST:

Naomi Colorow, Tribal Council Secretary