(Facility Name)

PATIENT FINANCIAL LETTER

DATE: ________________________

DEAR: _______________________ (Patient)

During your recent visit to _________________________(Hospital Name), we were unable to contact you to discuss payment or financial issues related to your hospital care. If you have insurance that will provide payment for your services, please provide that information below and return it immediately. If you have a copy of the insurance card, please provide that as well.

If you do not have insurance, we also offer a number of payment options:

1) Payment in full with Cash, Check, or Money Order.

2) Credit Card: VISA, MasterCard, Discover, or American Express.

3) Limited interest-free installments for up to six (6) months.

If you have any questions or need more information about any one of our payment options, please call our office at (123) 456-7890 or visit with a Financial Counselor in the ____________ (Hospital Location), Monday through Friday, 9:00 a.m. through 5:00 p.m.

Please remember that Full Payment is required upon receipt of billing.

Sincerely,

Financial Counseling Department

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INSURANCE VERIFICATION FORM

PATIENT'S NAME: __________________________________ACCT. NUMBER: ____________

If you have insurance, please complete and return to a Financial Counselor today. For your convenience, you may call (123) 456-7890 or FAX this form to (123) 456-7890.

Insured/Subscriber's Name:	
Insured/Subscriber's Social Security No:	
Group Number:	
Policy Number:	
Patient Relationship to Insured:	
Mailing Address:	
Medicare Number:	
Public Aid Recipient Number:	
Benefit Verification Telephone Number:	
Customer Service Telephone Number:	

PAYMENT COUPON FOR HOSPITAL SERVICES

PATIENT: ______________________________________ACCOUNT NUMBER: _________________

AMOUNT DUE: ___________________________________AMOUNT TO BE PAID: _______________

TO PAY BY MAIL:

____

____

(Hospital Name & Address)

TO PAY BY CREDIT CARD: *(Please indicate your credit card preference.)*

VISA _____ MASTERCARD _____ AMERICAN EXPRESS _____ DISCOVER _____

CREDIT CARD NUMBER: ________________________________ EXPIRATION DATE: ___________

CARDHOLDER NAME: ____________________________________ ZIP CODE: _________________

SIGNATURE: ____

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