

(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

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: _____