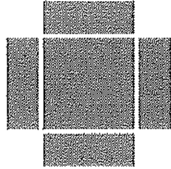
Debt Collection Policy

Attached is the Debt Collection Policy



Jasper Health Services, Inc.

VBO Manual for Jasper Health Services, Inc.

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General Information

Jasper Health Services, Inc. is made up of Jasper Memorial Hospital and The Retreat Nursing Home.

Jasper Memorial Hospital is a critical access hospital.

Retreat Nursing Home is a 55-bed hospital-based long term care facility located adjacent to Jasper Memorial Hospital. We will not be receiving nursing home accounts.

Quick Facts about Jasper Memorial Hospital:

- Beds: 25
- Type of Control: Governmental, County
- Total Patient Revenue: $13,069,936
- Total Discharges: 106
- Total Patient Days: 1,171

VBO Telephone Number 866-818-0278

898 College Street
Monticello, GA 31064
Main number: 706-468-6411

Patient Payment Address:

Jasper Health Services, Inc.
P.O. Box 698
Monticello, Ga 31064

Federal Tax ID #: **58-2510435**

NPI #: **1225031750**
1972715795 – swing beds

Provider Information

Payer	*Timely Filing Deadline*	*Payer ID*	*Comments*
Aetna	90 days from date of service	582510435	
Blue Cross Blue Shield	365 days from date of service	1225031750	HMO 90 days
Cigna	90 days from date of service	582510435	
Humana	120 days from date of service	582510435	
Medicaid	180 days from date of service	000000998A	
Medicare	365 days from date of service	111303	
United Healthcare	90 days from date of service	1225031750	

Contact Information

Business Office Mailing Address: P.O. Box 698, Monticello, GA 31064

Business Office Fed Ex. Address: 898 College Street, Monticello, Ga 31064

Business Office Hours: 8:00am to 4:00 pm (EST) Mondays – Fridays

Main contact: Amy Sofala
asofala@jaspermemorial.com
706-468-4503

Amy Sofala	***PFS Manager***
Jan Gaston	***Administrator***
Stuart Abney	***Controller***
Craig McCall	***Network Engineer***

Artiva Program Information

- **Artiva Client IDs**

Jasper Health Services, Inc. accounts will be separated into four (4) client IDs on Artiva. The client ID identifies self-pay and balance after insurance, balance after Medicare and Inventory Backlog. The client IDs will roll up to the client class VJASPER.

Artiva Client ID	Description
VJAS1A	Self-Pay
VJAS1B	Balance After Insurance
VJAS1C	Balance After Medicare
VJAS1D	Inventory Backlog

- **New Business:**

New business accounts will be placed daily.

- **Payments and Adjustments:**

Payments and adjustments will be reported to HSI daily.

- **Account Reconciliation:**

We will receive a reconciliation file from Jasper Memorial Hospital.

- **Close Process:**

Accounts not resolved in 120 days, will be closed back to Jasper Memorial Hospital unless there is pending insurance or the account is on a payment arrangement.

- **Client Account Number for Artiva:**

The encounter number will be used for the account number. The encounter number has 7 digits for the hospital and 6 digits for the clinic.

Workflow

Accounts will be placed with the VBO on day 1 from claim bill date for self-pay and we will receive balance after insurance accounts once the account becomes patient responsibility.

The VBO will have 120 days to resolve the accounts.

Once the account is placed with the VBO, it is immediately assigned to a follow-up representative to be worked within 15 days.

Ongoing follow-up occurs within a 7- 14 day time frame based on the activity required for resolution.

VBO GUIDELINES

- When speaking with patients, VBO will identify them as the Business Office.

- Jasper Health Services, Inc. does not have a payment portal. Credit card payments must be sent to Amy Sofala for processing. VBO will enter credit card information as well as insurance billing requests via the Offsite Portal in Artiva. An Excel spreadsheet is created from data entered into the portal and Customer Relations Center (CRC) sends the spreadsheet to Jasper password protected. It is categorized so Jasper's staff can sort the spreadsheet to fit their needs.

- Notes from HSI system will be uploaded daily into Cerner. Pertinent information will be entered into Cerner by VBO Reps until we get interface written with Cerner. Correspondence will be sent through SECURE EMAIL.

- BANKRUPTCY account information will be forwarded to Jasper Memorial Hospital's staff. Print the bankruptcy information that we receive from ARxChange and send to Amy Sofala at Jasper Memorial.

- VBO will be proactive in offering patient payment plans, monitor payments for calling when terms not met to insure proper aging of account.

- If a patient cannot pay, we should send them a financial assistance application and letter. Policy allows patient to apply for charity on balance after insurance. Financial Assistance Applications will be given upon request with return envelope to:

  Jasper Memorial Hospital
  Attn: Financial Counselor
  P.O. Box 698
  Monticello, GA 31064

- No discounts are given to employees.

- Jasper does accept insurance after discharge if it is still within timely filing limits. An ABN needs to be signed if the insurance is past timely filing limits so the patient accepts responsibility if the insurance does not pay. Jasper will file the claim.

- We will continue to work deceased accounts in search of an estate. Jasper Memorial Hospital does not file claims. We will try to get the spouse to accept responsibility.

- We should not receive any VIP accounts or employee accounts. Employee accounts should be closed and returned so they can be put on payroll deduction.

- Jasper Memorial Hospital does not write-off self-administered drugs. If patients complain, notify Amy and she may reduce the amount.

- If a guarantor provides a new address, our reps will update the information in Artiva and Cerner.

JASPER MEMORIAL HOSPITAL

PATIENT FINANCIAL ASSISTANCE PROGRAM (PFAP)
FREE AND REDUCED-CHARGE SERVICES APPLICATION

Name of Patient: ______________________ Date of Birth: ________

Name of Applicant: ____

Address: ____________________ City ____________________, GA Zip ____________

Telephone: ____________________ County: ______________________________

List members of household, birth date, relationship to patient, and income from each source; state whether income is per week, month, or year.

Name	Birth Date	Relationship	Income Wk/Mo/Yr	Total

(Continue on back, if necessary.)

Please provide a copy of your last (3) check stubs, a Tax return from prior year, or last (2) bank statements for income verification purposes.

If you have NO INCOME, please complete the following:

I, ______________________________, do attest that I have no reportable income for my household.

Support Statement: My signature will certify that I, ____________________(supporter) of the above applicant, do provide all necessary essentials for living for the applicant and have done so for a period of ____________ years/months (circle one).

Signature of Supporter ____________________ **Address of Supporter** ____________________ **Phone#** ____________

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in denial of this application. I understand that a credit report may be obtained or other measures may be taken to verify the information herein. I fully understand that Jasper Health Services, Inc. Patient Financial Assistance Program is a "Payer of Last Resort" and I hereby assign all benefits from any liability actions, personal claim injuries, tort settlements or any insurance benefits which may become payable for illness or injury for which Jasper Health Services, Inc. provided care.

Signature of Applicant/Guardian ______________________________ **Date** ____________

Please complete the following if there is <u>INCOME</u> in the household:

Self-Employment
A tax return is also required if you are self employed. However if income for any member of household is from self-employment and you were **NOT** required to file a tax return, you may give information on business costs so that we can determine actual income to be counted. Write details on back of this sheet. This also includes any "odd" jobs. (Example: cutting grass, cleaning gutters, handyman work, etc…)

If you do not receive a check stub, a letter signed from your employer stating the number of hours routinely worked and pay rate will be sufficient.

Please remember to list **ALL** income on application including the amount in SSI, Food Stamps, etc.

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in denial of this application. I understand that a credit report may be obtained or other measures may be taken to verify the information herein. I fully understand that Jasper Health Services, Inc. Patient Financial Assistance Program is a "Payer of Last Resort" and I hereby assign all benefits from any liability actions, personal claim injuries, tort settlements or any insurance benefits which may become payable for illness or injury for which Jasper Health Services, Inc./PCC provided care.

____ ____________________
Signature of Applicant/Guardian **Date**

TALK-OFF

Good (Morning, Afternoon, Evening), may I speak to (guarantor)? Hello, (guarantor), this is (representative) with Patient Financial Services, for security purposes, please verify the last (4) digits of your social security number, and date of birth. To keep our records updated, verify your current mailing address.

For quality assurance purposes, this call is being recorded.

I am calling in regard to your account with Jasper Memorial Hospital. The date of service (s) is/are _____ (date) ______, your balance is $______. You can resolve this balance by paying with a credit card today. I will hold the line while you gather your credit card information.

If the patient states they did not go to the hospital, ask if they visited the Primary Care Center.

Option 2: If patient cannot pay-off account with a credit card, "Can you resolve this balance within 7-10 business days with a check? The Account Representative should ask the following questions: What is your check number? What is the exact amount you are paying?

Option 3: If the patient cannot make a full payment commitment, reps should ask "How soon can you have this balance resolved?

Option 4: If a full commitment is not given, the representative should say "I can set-up a payment plan for you today. I can set that up for "DOLLAR AMOUNT" per month." Payment Monitoring Program explanation should be explained at this time.

Option 5: If everything fails with Option 2-3, the representative should offer a Financial Assistance Package by saying, "We have a Financial Assistance Program available for you at this time." Pre-Qualification questions should be asked.

Thank you for your cooperation. Have a nice day!

JASPER HEALTH SERVICES
BILLING AUTHORIZATION

______________________ Account Number

______________________ Patient Name

______________________ Date of Service

PRIMARY INSURANCE

______________________ Insurance Name

______________________ Insured's Name

______________________ Policy Number

______________________ Relation

SECONDARY INSURANCE

______________________ Insurance Name

______________________ Insured's Name

______________________ Policy Number

______________________ Relation

Attach copies of all Insurance Cards

1. In consideration of those hospital and medical services rendered by Jasper Memorial Hospital and or the Skilled Nursing Unit, I hereby (I) assign, transfer and set over to Jasper Memorial Hospital (II) all my rights, title and interest to medical reimbursement including but not limited to (III) the right to designate a beneficiary, add dependent eligibility and (IV) to have an individual policy continued or issued in accordance with the terms and benefits under my insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by Jasper Memorial Hospital.
2. I understand that I am financially responsible for all charges not covered by this assignment. It is further agreed that any credit balance resulting from payment of the insurance or other sources may be applied to any other account owed to the Jasper Memorial Hospital by me or a family member for whom I am financially responsible. If the payment has not been received from the insurance company within 45 days of the discharge date, the entire balance of this account becomes my responsibility.
3. I hereby authorize release of any information including medical history, physical findings, treatment and surgery or benefits payable for this or related claims to any organization responsible for payment on this claim or to any physician or medical service organization who will render care to the patient after discharge. It is understood that this release shall be irrevocable for one year following discharge, or until the hospital account is paid in full, whichever is greater.
4. MEDICARE AUTHORIZATION Patient's certification, authorization to release information, and payment request: I certify that information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians' services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment on my behalf.
5. **For Insurance presented after the date of service and/or discharge, I understand that I will be financially responsible for any penalties associated with pre-certification and/or timeliness. Furthermore, I accept responsibility for those penalties up to and including denial of total charges.**

X______________________________

Patient Date

______________________ Witness

Guarantor/ Person authorized to sign for patient Date

______________________ Relation

Signature of Guarantor: ______________________

Printed Guarantor Name: ______________________

LETTER SAMPLES

- VJASLET1 = First Letter
- VJASLET2 = Second Letter
- VJASLET3 = Third Letter
- VJASPPA = Payment Arrangement Letter
- VJASBP = Broken Promise Letter
- VJASBAI = Balance After Insurance Letter

P.O. BOX 723068
ATLANTA, GA 31139-0068

Jasper Health Services, Inc.

DO NOT REMIT PAYMENT TO THE ABOVE ADDRESS
SEE ADDRESS AT THE BOTTOM OF THE PAGE

11/13/2018

Toll Free Number: 855-891-8380

Tenemos también servicio al cliente en español

JOHN SMITH
1000 CIRCLE 75 PKWY SE
ATLANTA, GA 30339-3026

Account Number:	J00012345
Guarantor:	JOHN SMITH
Balance:	$ 350.00
Service Date:	06/30/2018

24153129

Dear JOHN SMITH,

Thank you for choosing Jasper Health Services, Inc. for your healthcare needs. We have billed the insurance carrier(s) that was provided at the time of service. If you have questions or concerns regarding your insurance payments, please contact your insurance company directly.

If you have already paid your account, we apologize for any inconvenience and look forward to serving you again. Please contact our office if you have questions or need to resolve the balance listed. Please remit payment for the balance listed on the payment stub.

Thank You,

Suzette Mangol

TO ENSURE PROPER CREDIT OF YOUR PAYMENT, PLEASE ENCLOSE THE BOTTOM PORTION OF THIS LETTER IN THE ENVELOPE PROVIDED
If you wish to pay by credit card, please provide the necessary information.

VJASLET1

Amount Remitted ____________________
Credit Card Number: ____________________
Security Code:_____ Exp. Date __________
Name ____________________
Signature ____________________

Account Number:	J00012345
Guarantor:	JOHN SMITH
Balance:	$ 350.00
Service Date:	06/30/2018

To ensure our customers receive quality service, we randomly select telephone calls for monitoring. These calls are evaluated by supervisors. This is to guarantee that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such service observing equipment.

JASPER HEALTH SERVICES, INC
P.O. BOX 698
MONTICELLO, GA 31064

P.O. BOX 723068
ATLANTA, GA 31139-0068

DO NOT REMIT PAYMENT TO THE ABOVE ADDRESS
SEE ADDRESS AT THE BOTTOM OF THE PAGE

11/13/2018

Toll Free Number: 855-891-8380

Tenemos también servicio al cliente en español

JOHN SMITH
1000 CIRCLE 75 PKWY SE
ATLANTA, GA 30339-3026

Account Number:	J00056789
Guarantor:	JOHN SMITH
Balance:	$ 250.00
Service Date:	05/29/2018

24153130

Dear JOHN SMITH,

Thank you for choosing Jasper Health Services, Inc. for your healthcare needs.

Unfortunately, our records reflect your balance is still unresolved. Please contact us at 855-891-8380 in order to satisfy the balance in full. Our representatives can also assist with establishing a payment plan, if that better suits your needs.

For your convenience, we accept VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER. If you have already paid your account, we apologize for any inconvenience and look forward to serving you again.

Thank You,
Suzette Mangol

TO ENSURE PROPER CREDIT OF YOUR PAYMENT, PLEASE ENCLOSE THE BOTTOM PORTION OF THIS LETTER IN THE ENVELOPE PROVIDED
If you wish to pay by credit card, please provide the necessary information

VJASLET2

Amount Remitted ____________________
Credit Card Number: ____________________
Security Code:______ Exp. Date ____________
Name ____________________
Signature ____________________

To ensure our customers receive quality service, we randomly select telephone calls for monitoring. These calls are evaluated by supervisors. This is to guarantee that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such service observing equipment.

Account Number:	J00056789
Guarantor:	JOHN SMITH
Balance:	$ 250.00
Service Date:	05/29/2018

JASPER HEALTH SERVICES, INC
P.O. BOX 698
MONTICELLO, GA 31064

P.O. BOX 723068
ATLANTA, GA 31139-0068

DO NOT REMIT PAYMENT TO THE ABOVE ADDRESS
SEE ADDRESS AT THE BOTTOM OF THE PAGE

11/13/2018

Toll Free Number: 855-891-8380

Tenemos también servicio al cliente en español

JANE SMITH
900 CIRCLE 75 PKWY SE
ATLANTA, GA 30339-3035

Account Number:	J000987654
Guarantor:	JANE SMITH
Balance:	$ 125.00
Service Date:	05/01/2018

24153131

Dear JANE SMITH,

This is a **FINAL NOTICE** regarding the below referenced account. You have 30 days to contact the business office and arrange a satisfactory resolution to your outstanding debt. If you cannot make payment in full, our representatives are available to assist you with other payment options.

Please contact us at 855-891-8380 to resolve your balance. For your convenience, we accept VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER. To avoid further collection efforts, please respond to this letter today.

Thank you for choosing Jasper Health Services, Inc. for your healthcare needs.

If you have already paid your account, we apologize for any inconvenience and look forward to serving you again.

Thank You,
Suzette Mangol

TO ENSURE PROPER CREDIT OF YOUR PAYMENT, PLEASE ENCLOSE THE BOTTOM PORTION OF THIS LETTER IN THE ENVELOPE PROVIDED
If you wish to pay by credit card, please provide the necessary information.

VJASLET3

Amount Remitted: ____________________
Credit Card Number: ____________________
Security Code:_____ Exp. Date __________
Name ____________________
Signature ____________________

Account Number:	J000987654
Guarantor:	JANE SMITH
Balance:	$ 125.00
Service Date:	05/01/2018

To ensure our customers receive quality service, we randomly select telephone calls for monitoring. These calls are evaluated by supervisors. This is to guarantee that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such service observing equipment.

JASPER HEALTH SERVICES, INC
P.O. BOX 698
MONTICELLO, GA 31064

P.O. BOX 723068
ATLANTA, GA 31139-0068

DO NOT REMIT PAYMENT TO THE ABOVE ADDRESS
SEE ADDRESS AT THE BOTTOM OF THE PAGE

11/13/2018

Toll Free Number: 855-891-8380

Tenemos también servicio al cliente en español

JANE SMITH
900 CIRCLE 75 PKWY SE
ATLANTA, GA 30339-3035

Responsible Party:	JANE SMITH
Reference:	J000987654
Amount Due:	$25.00
Due Date:	12/01/2018

24153131

Dear JANE SMITH,

Thank you for choosing Jasper Health Services, Inc. for your healthcare needs. An agreement has been made for a payment amount of $25.00 due on 12/01/2018. If you have any difficulty meeting this payment arrangement, please contact our office.

Please note the accounts marked with a + symbol are not included in your payment plan.
We encourage you to contact the busines office so these can be added to your existing agreement.

Account Number	Service Date	Account Balance
J000987654	05/01/2018	$125.00

Thank You,
Suzette Mangol,

TO ENSURE PROPER CREDIT OF YOUR PAYMENT, PLEASE ENCLOSE THE BOTTOM PORTION OF THIS LETTER IN THE ENVELOPE PROVIDED
If you wish to pay by credit card, please provide the necessary information.

VJASPPA

Amount Remitted ______________________
Credit Card Number: ______________________
Security Code:_____ Exp. Date __________
Name ______________________
Signature ______________________

Account Number:	J000987654
Due Date:	12/01/2018
Amount Due:	$25.00

To ensure our customers receive quality service, we randomly select telephone calls for monitoring. These calls are evaluated by supervisors. This is to guarantee that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such service observing equipment.

JASPER HEALTH SERVICES, INC
P.O. BOX 698
MONTICELLO, GA 31064

P.O. BOX 723068
ATLANTA, GA 31139-0068

DO NOT REMIT PAYMENT TO THE ABOVE ADDRESS
SEE ADDRESS AT THE BOTTOM OF THE PAGE

11/13/2018

Toll Free Number: 855-891-8380

Tenemos también servicio al cliente en español

JOHN SMITH
1000 CIRCLE 75 PKWY SE
ATLANTA, GA 30339-3026

Responsible Party:	JOHN SMITH
Due Date:	No active arrangement
Amount Due:	No active arrangement

24153130

Dear JOHN SMITH,

An arrangement was made with you to resolve your outstanding accounts. We have not received your payment as promised. Please send payment immediately. If any of these accounts have been resolved, please contact our office.

Account Number	Service Date	Account Balance
J00056789	05/29/2018	$250.00

Please note accounts marked with a + are not on a payment plan. We encourage you to contact the business office at (866) 818-0278 so these accounts can be added to your existing arrangement.

Thank You,
Suzette Mangol,

TO ENSURE PROPER CREDIT OF YOUR PAYMENT, PLEASE ENCLOSE THE BOTTOM PORTION OF THIS LETTER IN THE ENVELOPE PROVIDED
If you wish to pay by credit card, please provide the necessary information.

VJASBP

Amount Remitted: ____________________
Credit Card Number: ____________________
Security Code:_____ Exp. Date __________
Name ____________________
Signature ____________________

Account Number:	J00056789
Due Date:	No active arrangement
Amount Due:	No active arrangement

To ensure our customers receive quality service, we randomly select telephone calls for monitoring. These calls are evaluated by supervisors. This is to guarantee that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such service observing equipment.

JASPER HEALTH SERVICES, INC
P.O. BOX 698
MONTICELLO, GA 31064

P.O. BOX 723068
ATLANTA, GA 31139-0068

DO NOT REMIT PAYMENT TO THE ABOVE ADDRESS
SEE ADDRESS AT THE BOTTOM OF THE PAGE

11/13/2018

Toll Free Number: 855-891-8380

Tenemos también servicio al cliente en español

JOHN SMITH
1000 CIRCLE 75 PKWY SE
ATLANTA, GA 30339-3026

Account Number:	J00012345
Guarantor:	JOHN SMITH
Balance:	$ 350.00
Service Date:	06/30/2018

24153129

Dear JOHN SMITH,

Thank you for choosing Jasper Health Services, Inc. for your healthcare needs. A claim has been filed with your insurance company and they have notified us the remaining balance is your responsibility.

For your convenience, we accept VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER. Please contact us at 855-891-8380 to resolve your balance. Our representatives can also assist with establishing a payment arrangement if that better suits your needs.

Our representatives will be more than happy to provide you with a breakdown of your patient liability. However if you have questions regarding your current coverage, we encourage you to contact your insurance company for an explanation. Additionally, if there is other coverage not listed, please inform our representative when you contact us.

If you have already paid your account, we apologize for any inconvenience and look forward to serving you again.

Thank You,
Suzette Mangol

TO ENSURE PROPER CREDIT OF YOUR PAYMENT, PLEASE ENCLOSE THE BOTTOM PORTION OF THIS LETTER IN THE ENVELOPE PROVIDED
If you wish to pay by credit card, please provide the necessary information.

VJASBAI

Amount Remitted ____________________
Credit Card Number: ____________________
Security Code:_____ Exp. Date ___________
Name ____________________
Signature ____________________

To ensure our customers receive quality service, we randomly select telephone calls for monitoring. These calls are evaluated by supervisors. This is to guarantee that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such service observing equipment.

Account Number:	J00012345
Guarantor:	JOHN SMITH
Balance:	$ 350.00
Service Date:	06/30/2018

JASPER HEALTH SERVICES, INC
P.O. BOX 698
MONTICELLO, GA 31064