ANDROSCOGGIN VALLEY HOSPITAL
A CRITICAL ACCESS HOSPITAL

Financial Assistance

Responsible Individual: Director, Revenue Cycle Services
Approved By: Board of Directors
April 29, 2021

Purpose

To outline Androscoggin Valley Hospital (Hospital or AVH) and/or AVH Surgical Associates (ASA) policies regarding financial counseling, financial assistance, patient payments and billing and collection practices.

The purpose of this policy is to provide guidelines for determining financial assistance for patients who receive emergency and other medically necessary services at Androscoggin Valley Hospital and are unable to pay balances after insurance and for which there is no other source of funding available.

Responsibility

The Customer Service Department is responsible for processing all financial assistance requests.

Policy Scope

For purposes of this policy, financial assistance requests pertain to the provision of healthcare services delivered by AVH and/or ASA for emergent and medically necessary care. This policy is limited to the charges billed by AVH/ASA and does not include any physician, pathology or ancillary charges not billed by AVH/ASA (Attachment D).

General

Androscoggin Valley Hospital is committed to providing financial assistance to persons who have healthcare needs and are uninsured and underinsured, and otherwise unable to pay, for medically necessary care based on their individual financial situation. The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social, or immigrant status, sexual orientation or religious affiliation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services, the Hospital strives to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care. The Hospital will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

Accordingly, this written policy:

- Includes the eligibility criteria for financial assistance.
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy.
- Describes the method by which patients may apply for financial assistance.
- Describes how the hospital will widely publicize the policy within the community served by the hospital.

Financial Assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with the Hospital's procedures for obtaining financial assistance or other forms of payment or assistance, and to contribute to the cost of their care based on their individual ability to pay.

In order to manage its resources responsibly and to allow the Hospital to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors has established the following guidelines for the provision of patient financial assistance.

Definitions

For the purpose of this policy, the terms below are defined as follows:

Amount Generally Billed (AGB) – The amount generally billed for emergency or other medically necessary care to

individuals who have insurance covering such care.

Assets are defined as savings, certificates of deposit, checking accounts, investment accounts, retirement accounts and real estate property other than primary residence.

Days when referenced shall mean calendar days unless otherwise specified herein.

Elective Services are defined as services that are not emergent or medically necessary.

Emergency Medical Conditions are defined within section 1867 of the Social Security Act (42 U.S.C. 1395dd) as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction to any bodily organ or part, or
- with respect to pregnant woman;
- that there is inadequate time to effect a safe transfer to another hospital before delivery, or
- that the transfer may pose a threat to the health or safety of the woman or the unborn child.

Extraordinary Collection Actions (EAC) as proposed through the Internal Revenue Code Section 501®, are actions that require a legal or judicial process, including without limitation, liens on residences, writs of body attachment, foreclosures on property, seizing a bank account, civil actions against an individual, wage garnishment, sales of debt, and arrest.

Family/Household is defined using the Internal Revenue Service(IRS) rules that define who may be claimed as an exemption/dependent for tax purposes are used as a guideline to validate family size in granting financial assistance.

Family/Household Income is calculated using the federal poverty guidelines which are based on; earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, alimony, child support, capital gains, and other miscellaneous sources;

Federal Poverty Guidelines (FPG) are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current guidelines can be referenced at http://aspe.hhs.gov/poverty/. The Hospital will review and update Financial Assistance Allowances based on the current FPG on February 1st of each year.

Gross Charges are the total charges at the organization's full established rates for the patient's health care services before contractual allowances, other deductions from revenue or negotiated discounts are applied.

Medically Necessary for the purpose of this policy will be defined using New Hampshire regulations which define medically necessary as "health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

1. Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;
2. Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;
3. No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and
4. Not experimental, investigative, cosmetic, or duplicative in nature."

Presumptive Eligibility is defined as patients who may be presumed or deemed eligible for financial assistance based on their enrollment in other programs or on information that is not provided directly by the patient.

Uninsured Patient (also known as self-pay) is defined as an individual without active health insurance at the time of service to cover costs of services provided by Androscoggin Valley Hospital.

Underinsured Patient is defined as an individual having health insurance coverage which does not cover the entire costs of services provided by the Androscoggin Valley Hospital.

Financial Counseling

AVH will make every reasonable effort to provide financial counseling to patients prior to any scheduled appointment, test or procedure. For unscheduled admissions AVH will make every reasonable effort to provide financial counseling within two business days.

Financial Counseling will consist of a discussion of potential liability, financial assistance available, payment plans and shall include applying for Medicaid, Disability and Marketplace plans offered through the Affordable Care Act.

Financial Assistance

AVH/ASA has Financial Assistance available for medically necessary services, to persons who have healthcare needs and are uninsured and underinsured, and otherwise unable to pay based on their financial situation. If applicant(s) are approved financial assistance it will be applied to balances up to 240 days from initial statement and one (1) year from the date of application for future services.

Determining Eligibility for Financial Assistance

Patient's residency will be taken into account in determining services discounted under the financial assistance policy:

RESIDENCY:
Unscheduled services - No residency requirement.
Planned, scheduled, non-emergent services - A driver's license or non-driver license ID will be required if address on supporting documentation is not within the service areas listed below.

SERVICE AREA:
Unscheduled services - No residency requirement.
Planned, scheduled, non-emergent services - Coos, Grafton and Carroll County, NH, Oxford County ME and Essex County, VT.

A cover letter is attached to the financial assistance application indicating the supporting information required to make a determination of financial assistance (Schedule B).

Eligibility for financial assistance will be considered for those individuals who are uninsured and underinsured and who are unable to pay for the balance of their care, based upon a determination of financial need in accordance with this Policy.

AVH/ASA does not provide financial assistance for purely elective services or patient convenience. The determination of which services are considered elective resides solely with AVH/ASA. Examples of services and supplies that are ineligible for financial assistance are found in Attachment C (Excluded Procedures/Service/Supplies).

Financial need will be determined in accordance with procedures that involve an individual assessment; and will:

A. Include an application (Attachment B), process in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need. If a patient is unable to complete the application form, Customer Service Department personnel will assist the patient in the completion of the application. AVH certifies all information contained within or attached to the application will only be used to determine eligibility for the Hospital financial assistance program. AVH and its employees will not release a patient's application or attachments without documented permission from the applicant(s).

B. Include reasonable efforts by the Hospital to explore appropriate alternative sources of payment and coverage from public and private payment programs and to assist patients to apply for such programs.

C. Take into account the patient's available assets, income, investments, equity in real estate property within the guidelines of the program, and all other financial resources available to the patient.

D. Presumptive eligibility will be determined using a copy of household's notice of decision from the Department of Health and Human Services. The notice must be complete and dated within the last 6 months from the date of application. The notice must show the income and resources calculation and cannot indicate that the application was denied for lack of requested information or that the patient withdrew their application for assistance. In the event the household is determined eligible from the notice of decision they will receive an approval valid for the 240 day application period and for 6 months from the date of the DHHS notice of decision prospectively. If a patient wishes to continue to receive FA then they will be required to complete the FAP application process.

AVH allows a 100% discount to applicants whose household income, earned and unsheltered, is below 300% of the poverty level (Attachment A).

Determining Household Income: Household income is calculated using the combined gross total of earned and unearned income, for a 12-month period, for all members of the household including any unsheltered assets.

Determining Household Assets: The values of assets considered in this policy are added together or in the case of bank accounts averaged over three months. If the patient's assets exceed $2,500 for a household of one or $4,000 for a household of two or more, the additional amount will be added to the household income. The current value of a household member's retirement accounts will be sheltered up to $100,000 of the funds, and the additional amount will be added to the household income. Second, third, etc. property will not be sheltered. However, if patient is only a part owner in the property by default (inherited) and can prove he/she does not contribute monetarily to the property, the asset need not be counted.

Patients and guarantors will be notified of the status of their financial assistance application in writing. Once approved a financial assistance determination is good for one (1) year from the date of the application before a patient or guarantor is required to re-apply

Requests for financial assistance shall be processed promptly and the Hospital shall notify the patient or applicant in writing within 30 days of receipt of a completed application and all supporting documentation. The processing of the application may be delayed if necessary information was not supplied or the patient has a Medicaid eligibility determination pending.

Once a patient is been determined to be eligible for financial assistance, the patient will receive a letter in the mail explaining the amount of discount they are eligible for and the expiration date of their assistance and an itemized statement reflecting the financial assistance amount, AGB (if applicable) and amount due by patient.

Denial or Revocation of Financial Assistance

Financial assistance will be denied or revoked under the following situations:

- The patient provides false information on the application.
- The patient does not meet the eligibility criteria under this policy.
- AVH reserves the right revoke future financial assistance should the family financial circumstances improve or they have a change in family size.
- Financial assistance is only granted after all other sources of payment have been exhausted.
- Failure to apply for Medicaid or any other assistance program that the patient may be eligible for.

Change in Circumstances

Patients/Individuals may reapply for financial assistance at any time if their circumstances change. A new application and supporting documentation is required. Please contact the Customer Service Department at (603) 326-5628 with any questions.

Method by Which Patients May Apply for Financial Assistance
Patients can obtain financial assistance applications at the following locations:

Androscoggin Valley Hospital
Customer Service Department, 1st floor
59 Page Hill Rd
Berlin, NH 03570

Androscoggin Valley Hospital
Registration Department
Emergency Room Area, 2nd Floor
59 Page Hill Rd
Berlin, NH 03570

Applications may also be requested at any registration location within the hospital and Androscoggin Valley Hospital Surgical Associate's Professional building.

Applications are also available for download at www.avhnh.org.

A patient or other designated person may contact the Financial Counselor at (603)326-5653 or the Financial Specialist at (603)326-5661 to have an application mailed to them.

Assistance in completing the application is available by telephone at (603)326-5653 or (603)326-5661or in person.

Amounts General Billed (AGB) and Discounts

The Hospitals AGB is determined using the Look-Back Method by taking the total gross charges less the contract allowances and dividing that number by the total charges. Any financial assistance eligible insured or underinsured patient will not be charged more for emergency or medically necessary care than the AGB.

Uninsured (pure self-pay) patients are eligible for an uninsured patient discount on all accounts with the exception of elective services to comply with State law.

A 10% discount is also available for all self-pay balances due by patients when the balance is paid within 25 days of the mailing date of the patient's initial statement.

Patient Payments

AVH/ASA will collect appropriate co-payment or deposit as determined by the Patient Registration and Customer Service Departments on, or before the time of service except in the event of a medical emergency in accordance with the Emergency Medical Treatment and labor Act (EMTALA). In the event of a medical emergency, payment will not be collected until the patient has been triaged, stabilized or discharged to home.

Whenever possible patients should be told in advance of their potential liability and at a minimum patients are to be told that co-pays will be collected at the time of service during scheduling. A patient will not have to make payment at the time of service if they have been approved for Financial Assistance.

AVH/ASA staff is responsible for ensuring that payments are processed timely and accurately, following established cash handling procedures. The Patient Accounts Manager, along with any departmental managers or directors for areas where cash collections are accepted, have the overall responsibility for ensuring that payments collected at the time of service are processed according to procedure and for ensuring staff compliance with collection policies.

Patients that indicate an inability to meet their financial obligations are to be referred to the Customer Service department. If the patient is already scheduled for a test or procedure the ordering provider will be consulted to see if the patient can be rescheduled until the patient can be approved for financial assistance or a payment arrangements can be made. If the patient should not be rescheduled, Customer Service Department Personnel will continue to work with the patient regarding financial assistance qualifications or payment arrangements.

Payment Plans

A monthly payment plan can be established using the guidelines outlined in the Payment Plans Procedure.

Communication of the Financial Assistance Program to Patients and Within the Community

Notification of financial assistance, which includes contact numbers, are located, but are not limited to, the Customer Service Department, emergency area, registration areas at AVH/ASA, online at www.avhnh.org, patient statements and AVH/ASA television monitors within the buildings and other public places (i.e. Service Link, Coos County Family Health Service). .

The plain language summary (PLS), this financial assistance policy (FAP) and the application form are all located on the Hospital web site at www.avhnh.org. The PLS, FAP and application are available in English and in French.

Billing and Collection Processes

AVH/ASA will make concerted efforts to engage patients in financial assistance and determination of eligibility for financial assistance.

Beginning on day 1 of the statement cycle patients with a self-pay balance will be sent a statement. There will be a series of three (3) statements and two (2) attempts to reach by telephone in the first 90 days. At or about day 90, a final notice will be sent giving the patient thirty (30) days to make payment arrangements, apply for financial assistance or discuss other options which may be available to them in order to avoid their account being place with a collection agency and subject to possible extraordinary collection efforts. After day 120, account will be placed with an outside collection agency.

AVH/ASA

Patient/guarantor statements will indicate Financial Assistance, a payment plan or other options may be available and give information on who to contact or were an application can be obtained. The Hospital's web site www.avhnh.org is also listed on the statement. Customer Service Department Personnel are available to discuss options and to assist patient with the Financial Assistance, setting up a payment plan or with application for other sources of payment.

For uninsured and underinsured patients, a financial assistance application will be accepted and underwritten for approval up to 240 days from the initial statement date. Any accounts placed with an outside collection agency between days 120 and 240 will be returned by the collection agency and financial assistance will be applied. Accounts will not be reported to a credit reporting agency by the outside collection agency.

Patient/Guarantor accounts are documented regarding the nature of the conversation during and after each telephone call or visit to the Customer Service Department.

The Hospital will not impose extraordinary collection actions such as wage garnishments, liens on primary residences or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for financial assistance. Accounts will not be placed with an attorney for collection until after the 240 days from the initial statement to patient. A final notice statement or letter will be sent to the patient 30 days prior to the placement with an outside collection agency or attorney.

Regulatory Requirements

In implementing this Policy, the Hospital management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

Rescission

This document rescinds and replaces the Board of Directors policy, Financial Assistance Policy, dated March 23, 2017.

_____
Leslie Haddy
Director, Revenue Cycle Services

_____
Richard Werkowski, MBA, BS, FHFMA
Interim CFO

_____
Donna Goodrich
Chair, Board of Directors

Attachment A

AVH and ASA
Financial Assistance Allowances - 2021
Effective 01/13/2021

2021 GROSS INCOME GUIDELINES

Family Size	100% Discount Based on 300% of the Poverty Guidelines
1	$38,640
2	$52,260
3	$65,880
4	$79,500
5	$93,120
6	$106,740
7	$120,360
8	$133,980

Add the following Amount for Each Additional Family Member (over 8): $13,620

2021 Poverty Guidelines published in the February 01, 2021, Federal Register.

Attachment B

NC | Androscoggin Valley Hospital

Dear Patient:

If payment of health care expenses could create a financial hardship please complete the attached application if you have or had a planned, scheduled, non-emergent service and are a resident living in Coos, Grafton or Carroll County in NH, Oxford County, ME or Essex County, VT. If you had unscheduled services, no resident requirements apply. For more information, please contact Customer Service Department Personnel by calling 603-326-5628 or visit the Customer Service Department located on the first floor of the hospital. Look for the Customer Service/Financial Counseling signs.

The application and supporting documentation required will help us determine if you are eligible for financial assistance at Androscoggin Valley Hospital (AVH) and/or Androscoggin Valley Surgical Associates (ASA). This is an income and asset based program. **Any information provided is confidential.** Please use the check list below to ensure all the necessary information needed to process the application has been included/or ***all members living in the household and/or included on the Federal Income Tax Return.***

Please call if clarification is needed prior to submitting the application at the telephone numbers listed above.

1. Completed application signed by all household/family members 18 years or older. 0
2. Proof of residency - driver's license or non-driver ID will be required if address on supporting documentation is not within the service areas listed above. 0
3. **Complete** copy of most recent Federal Income Tax Return(s) (i.e. 2020 return will be accepted until April 18, 2021 unless 2021 return is available) WITH ALL schedules AND W-2's. **0**
4. Copy of the four (4) most recent consecutive paycheck stubs or a statement from employer showing the gross income total for one month. **0**
5. Copy of **ALL pages** of the three (3) most recent bank statements (i.e. savings, checking, money market account, certificate of deposit). Verification of deposits over $5000 may be required. **0**
6. Copy of most recent retirement or investment statements (i.e. 401K, 403B, IRA, Mutual Fund, stocks, bonds). **0**
7. Copy of all income sources (i.e. annual social security, Veteran's (VA) or pension benefit letters, unemployment or workers compensation letter, disability compensation benefitstatements, etc.). **0**
8. Copy of medical assistance letter (i.e. Dept. of Health and Human Services) or health insurance card. **0**
9. Copy of current property tax bill with assessed value AND copy of mortgage statement with current outstanding balance for property excluding primary residence (i.e. 2nd home, cottage, camp, land, rental etc.). 0

You will continue to be financially responsible for any services you receive until eligibility is determined. If you have not received a determination within thirty (30) days of submitting your completed application and supporting information, or if you need help completing the application, please contact the Customer Service Department at 603-326-5628.

Completed applications and supporting documents should be returned to: Androscoggin Valley Hospital, Attention: Customer Service Department, 59 Page Hill Road, Berlin, NH 03570.

Attachment B (continued)

Financial Assistance Application

NCH north country healthcare | Androscoggin Valley Hospital

1. Patient's Information

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Street Address	City	State	Zip Code

Mailing Address	City	State	Zip Code

Home Phone Number	Other Phone Number

Marital Status (circle one):

Single	Married	Civil Union	Separated	Divorced	Widowed

Citizenship Status (circle one):

U.S. Citizen	VT Resident	NH Resident

2. Person Responsible for Paying the Bill

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Street Address	City	State	Zip Code

3. Household Information

** Please indicate ALL people living in the household, including the applicant: (Use additional sheet of paper if needed)

	Name	Relationship to Patient	Date of Birth	Social Security #	Applying for assistance?
1.					YES / NO
2.					YES / NO
3.					YES / NO

A. Is this application for future or past services? (circle) **FUTURE / PAST**

B. Does anyone in your household have insurance? (circle) **YES / NO**

Health Insurance Policy Name:

Policy / ID #:

Health Savings Account? (circle) **YES / NO**

C. Has anyone in your household applied for Medicaid? (circle) **YES / NO**

D. Have you applied for financial assistance at another facility? (circle) **YES / NO** If yes, where?

E. Is anyone in your household pregnant? (circle) **YES / NO**

F. Has anyone in your household served in the military? (circle) **YES / NO**

G. Have you recently filed a workers' compensation or motor vehicle accident claim? (circle) **YES / NO** If yes, when:

H. Is anyone in your household eligible for Social Security Benefits? (circle) **YES / NO**

I. Does anyone in the household pay child support? (circle) **YES / NO** If yes, monthly amount paid:

J. Does anyone else claim you on their income tax return? (circle) **YES / NO** If yes, who:

K. Are there any adults in the household who do not have any income? (circle) **YES / NO** If yes, who:

L. Are there any adults in the household who do not have any bank accounts? (circle) **YES / NO** If yes, who:

Attachment B (continued)

NCH north country healthcare | Androscoggin Valley Hospital

4. Household Income Information

	Person 1	Person 2	Person 3
Name of each household member:			
Name of your employer:			
Gross Monthly Income from:			
Employment:			
Self-Employment:			
Investment Accounts:			
Real-Estate rentals:			
Unemployment:			
Retirement:			
(Social Security, pension, annuities)			
Alimony / Child Support:			
Other income:			
Savings and Investments:			
Checking Account Balances:			
Savings & CD Account Balances:			
IRA, 401k, 403b Balances:			
Other savings & investments:			
Other:			
Automobile (Year, Make, Model)			
Recreational Vehicle (Year, Make Model)			

5. Household Expenses

Do you own property other than your primary residence? (circle) **YES / NO** If yes, additional information may be requested

Monthly Rent Payment:_____
Monthly Mortage Payment:_____
Medicare Part B, Part C, or Part D deducted from Social Security Check: _____

6. Assignment of Rights *(Read Carefully)*

By signing below I authorize the request for my credit report and/or tax return. I understand that a tax return is needed to process this application and that more information may be requested before my eligibility can be determined.

In the event that I have not fully disclosed, or have inaccurately represented, any income or assets, any agreement to provide you with a charitable care discount would be null and void and would be retroactive back to the date the bills were owed. I may be liable for any/all legal fees during the collection process.

All adult household members who sign below authorize the release of any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care providers from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures might not be considered for assistance.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, award from a lawsuit or any other payment.

If I receive Financial Assistance, I agree to tell the organization where I first applied of any changes which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

Applicant Signature _____ Date _____

Co-Applicant Signature _____ Date _____

Attachment B (continued)

Application Addendum

PLEASE ANSWER THE FOLLOWING QUESTIONS TO ASSIST US IN MAKING A DETERMINATION ON YOUR APPLICATION.

If the question does not pertain please answer N/A.

If you are currently unemployed, when was your last day of work?_____

Are you eligible for unemployment compensation?_____

If you are temporarily out of work, do you expect to return to the same job?_____

If so, when?_____

Are you a parent who is unable to work because of health reasons?_____

Are you a single parent with more than 50% custody of your child/children?_____

Do you receive Social Security benefits as a result of a disability?_____

Do you have health problems that limit your ability to work?_____

Do you have a whole life insurance policy?_____

If you did not enclose a copy of last year's tax return, please indicate the reason why:

___ Do not have to file - retired.

___ Did not make enough money to file.

___ Did not keep a copy of last year's tax return.
Please contact us at 326-5628 to request a transcript of tax return form.

Attachment B (continued)

Authorization to Release Information

I hereby authorize and request:

Name and Address of Individual or Agency Providing the Information

The NH Department of Health and Human Services
Berlin District Office, Littleton District, other district office, and/or Central Medicaid Unit

to provide the following information: The status of my application for assistance and/or what information maybe still required for a determination to be made. A copy of my notice of decision(s), information (verbal and/or written) regarding my eligibility, approval, or denial for all programs. The amount of my monthly spend down. Information regarding why my case closed.

to:

Name and Address of Individual or Agency Receiving the Information

Androscoggin Valley Hospital, ATTN: Customer Service Department,
59 Page Hill Road, Berlin, NH 03570

Fax: 603-326-5658, Telephone: 603-326-5628

I grant my permission for the reproduction of the above information to be given to the individual or agency names. Release of confidential information is subject to State and Federal laws. By signing this release, I acknowledge my permission to release the specified information to the individual/agency I have named.

This authorization expires **in one year**

(Date)

Information released cannot be re-released by the receiving individual/agency without additional authorization.

(Signature) (Date)

(Printed Name) (Date of Birth)

If the signature above is not that of the person to whom the information pertains, the relationship of the signer to that person must be indicated. In addition, the signature must be witnessed.

(Relationship) (Witness)

(Date)

Attachment C

PATIENT- YOU MUST KEEP THIS PAGE FOR COVERAGE REFERENCE

Excluded Procedures/Services/Supplies for Reduced Charges

Bariatric medicine: exercise programs (payment is due prior to service).

Cosmetic procedures/services (physician services and related hospitalization), including charges for plastic and cosmetic surgery, botox injections, laser treatment (i.e. hair removal, spider veins, facial and neck, wrinkle reduction, pigmented lesions, etc.).

Dental services.

Diabetic Education for weight loss only. Must have valid diagnosis (i.e. diabetes, renal disease)

Experimental/Investigational procedures (i.e. fertility treatment and testing) except initial physician consultation charge.

Insurance company claims denied for lack of referral/pre-certification that the patient is required to obtain or for patient failure to submit information being required by the insurance company.

Occupational Health Services.

Physical exams and related services for work or insurance purposes or as required for other administrative or liability reasons.

Services or procedures for any condition, disease or injury arising out of or in the course of employment, when the member has the opportunity to be covered by a Workers' Compensation Program.

Services or procedures as a result of any accident covered by any liability insurance.

Sex transformation procedures and related services.

Sterilization and/or reversal of voluntary sterilization charges. Physician consultation charges for discussion of possible sterilization and/or reversal will be covered.

Supplies, including but not limited to: hearing aid(s) and batteries, custom or other earplugs, swimming headband, botox serum, cast cover, durable medical equipment.

02/2016

Attachment D

Provider List

The Androscoggin Valley Hospital (AVH) and Androscoggin Valley Hospital Surgical Associates (ASA) Financial Assistance Policy will not be applied to charges for emergency and medically necessary care rendered at AVH/ASA if those charges are not billed by AVH/ASA for the provider.

Providers, from other facilities, providing emergency and medically necessary care at AVH/ASA are not covered under the AVH/ASA financial assistance policy and charges for their services will be billed by their facility.

Covered and non-covered provider facilities are listed below:

Covered

Androscoggin Valley Hospital
Androscoggin Valley Hospital Surgical Associates

Non-Covered

Catholic Medical Center/New England Heart Institute
Coos County Family Health Services
Dartmouth Hitchcock Medical Center
Eyesight Ophthalmic Services
I Rhythm
Implantable Product Group (IPG)
Littleton Regional Health Care
Memorial Hospital
North Country Dental
North Country Radiology
Upper Connecticut Valley Hospital
Weeks Medical Center