

# **Credit and Collection Policy**

## Hallmark Health System

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## Hallmark Health Credit and Collection Policy

### I. INTRODUCTION

This Credit and Collection policy applies to Hallmark Health, commonly referred to as the “Hospital” throughout this policy. Hallmark Health is comprised of Melrose-Wakefield Hospital, a not-for-profit, full service hospital located at 585 Lebanon Street, Melrose, MA 02176, and Lawrence Memorial Hospital, a full service hospital, located at 170 Governors Avenue, Medford, MA 02155. Hallmark Health is a front line caregiver providing medically necessary care for all people regardless of ability to pay. Hallmark Health offers this care to all patients who come to our facility 24 hours a day, 7 days a week and 365 days a year.

Hallmark Health shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, disability, substance abuse, socio-economic status, lack of insurance, or physical appearance in providing its services. This applies to both the substance and application of the Hospital’s policies concerning the acquisition and verification of financial information, pre-admission or pre-treatment deposits, payment plans, deferred services or admissions, low income patient status, and billing and collection practices.

This Credit and Collection Policy is concerned with preserving the Hospital’s assets and maintaining a sound financial basis for its operations while at the same time balancing the needs of our community and the patients we serve. This policy sets forth the Hospital’s general guidelines for acquiring and verifying information, for classifying patients according to their ability to pay, and for collecting payment from third party insurance companies, patients, their guarantors, and others financially responsible for the payment of health care services. The Hospital’s policy is to comply with the requirements under applicable state and federal laws in performing these functions and to update its practices as such laws are amended from time to time.

Patients who have the means are expected to pay for services provided by Hallmark Health. This policy assumes that patients who have access to affordable insurance will apply for and maintain their coverage. In the event patients are unable to pay, the Hospital assists them in obtaining financial assistance from government programs and other sources for medically necessary services whenever appropriate. To remain viable as it fulfills its mission, Hallmark Health must meet its fiduciary responsibility to appropriately bill and collect for medical services provided to patients. This Credit and Collection Policy was developed to ensure compliance with applicable laws including but not limited to: (1) the State’s Health Safety Net Eligibility regulation (101 C.M.R. § 613.00); (2) 111 M.G.L. § 228; (3) the Centers for Medicare and Medicaid Services (“CMS”) Medicare Bad Debt Requirements (42 CF.R. § 413.89); and (4) Section 501(r) of the Internal Revenue Code.

The Board of Trustees designated the Hospital’s Chief Financial Officer as responsible for ensuring that a current electronic copy of this Credit and Collection Policy is on file with the Health Safety Net Office along with supporting documentation and exhibits.

This policy applies to services delivered and billed by the Hospital at the locations set forth in [Appendix A](#) - Hallmark Health Locations, Participating Entities. This policy does not apply to services delivered and billed by the entities listed in [Appendix B](#) - Hallmark Health Provider Affiliate List, Non-Participating Entities, even in the case where such services may be rendered in the Hospital locations set forth in [Appendix A](#).

### II. DELIVERY OF HEALTHCARE SERVICES

#### A. General Principle

All patients presenting for unscheduled treatment will be evaluated according to the classifications included in this section. Emergency or Urgent Services (as defined in [Section II\(B\)](#) below) shall not be denied or delayed based on the Hospital’s ability to identify a patient, their insurance coverage, or ability to pay. However, Non-Emergency, Non-Urgent Services (as defined in [Section II\(C\)](#) below) may be indefinitely postponed in those cases when the Hospital is unable to determine a payment source for the services, based on consultation with the patient’s treating clinician.

The urgency of treatment associated with each patient’s presenting clinical symptoms will be determined by a medical professional in accordance with local, state, and national clinical standards of care, and the Hospital’s medical staff policies and procedures. It is important to note that classification of patients’ medical conditions are for clinical management purposes only, and such classifications are meant to address the order in which the Hospital’s

clinical staff should see patients based on their presenting clinical symptoms. These classifications do not reflect medical evaluation of the patient's medical condition as reflected in the final diagnosis.

**B. Emergency and Urgent Services**

*“Emergency Services”* as referred to in this policy include: Medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in 42 U.S.C. § 1395dd(e)(1)(B). A medical screening examination and any stabilizing treatment for an emergency medical condition, including but not limited to inpatient medical care or any other such service rendered to the extent required under EMTALA (42 U.S.C. § 1395(dd)), qualifies as Emergency Services.

*“Urgent Services”* as referred to in this policy include: Medically necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in placing the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health.

EMTALA Level Requirements: In accordance with the federal Emergency Medical Treatment and Labor Act (EMTALA), the Hospital is required to provide a medical screening examination to all individuals who present to the Hospital's emergency department requesting care for a medical condition, and to all individuals who present on Hospital property requesting care for an emergency medical condition in order to determine whether such individual is, in fact, experiencing an emergency medical condition. If a physician or other qualified medical personnel at the Hospital determines that a patient is experiencing an emergency medical condition, the Hospital is further obligated under EMTALA to provide the individual with stabilizing treatment within its capacity and capabilities. The extent of the Hospital services necessary to provide an appropriate medical screening examination as well as the scope of the treatment required to stabilize the emergency medical condition as required under EMTALA, which may include but is not limited to inpatient admission, is provided to the patient based on the assessment made by physician or qualified medical personnel of the hospital as documented in the medical record.

**C. Non-Emergency, Non-Urgent Services**

*“Non-Emergency, Non-Urgent Services”* as referred to in this policy generally include either medically necessary services that do not meet the definition of Emergency or Urgent Services set forth in Section II(B) of this policy, or services that a treating clinician has determined are not medically necessary such as nonmedical services (e.g., social, educational, or vocational, cosmetic surgery, research, and other) (the latter category of services may be described in this policy as *Non-Medically Necessary Services*). The patient typically, but not exclusively, schedules these services in advance. The Hospital may decline to provide a patient with Non-Emergency, Non-Urgent Services in those cases when the Hospital is not successful in determining that payment will be made for the services.

**D. Locations that Patients May Present for Services**

Reference Appendix A.

**III. COLLECTION AND VERIFICATION OF PATIENT INFORMATION**

It is the patient's obligation to provide complete and timely insurance and demographic information to the Hospital and to know what services are covered by their insurance policy. The Hospital will make diligent efforts to positively identify all patients and obtain, record, and verify complete demographic and financial information for every patient seeking care. The information to be obtained includes demographic information (such as patient name, address, telephone number, social security number, gender, date of birth, and other applicable patient information) and health insurance information (including name and address,

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policy number, group number, subscriber information, and benefit information such as co-payments, deductibles, and co-insurance) that is sufficient to secure payment for services. The requirement for the Hospital to obtain complete information shall take the patient's condition into account with the patient's immediate health care needs taking priority. For inpatients, verification may occur at any time during the provision of services, at discharge, or during the collection process. For outpatients, verification may occur at the time the patient receives Non-Emergency, Non-Urgent Services or during the collection process.

### A. Emergency and Urgent Services

Registration and intake of Emergency and Urgent patients will be performed in accordance with the requirements of EMTALA. Generally, patient demographic and insurance information may be collected in accordance with the Hospital's normal registration process as long as such collection does not delay the provision of the medical screening examination and/or any stabilizing treatment. Where a patient is unable to provide demographic or insurance information at the time of service and the patient consents, every effort should be made to interview relatives or friends that may accompany or otherwise be identified by the patient. Where practical, insurance information provided by the patient should be confirmed with the payer via electronic means or other available methods. Under no circumstance, however, shall Hospital staff verify a patient's insurance status, obtain pre-approval from third party payers, or give the patient financial responsibility forms prior to the medical screening examination and initiation of any stabilizing treatment.

### B. Non-Emergency, Non-Urgent Services

Registration and intake of Non-Emergency, Non-Urgent patients should be performed prior to services being rendered. Returning or established patients will also have the demographic, insurance, and financial information reviewed and updated as needed, including where applicable, verification of their insurance status via electronic or other available methods. Patients have the responsibility to update insurance and demographic information with Registration.

## IV. DETERMINATION OF PATIENT FINANCIAL RESPONSIBILITY

### A. General Principles

The Hospital will make diligent efforts to determine the patient's financial responsibility as soon as reasonably possible during the patient's course of care; provided that, screening and the initiation of any stabilizing treatment consistent with EMTALA will be completed for Emergency or Urgent patients prior to activities to determine a patient's financial responsibility. Patients who are members of managed care health plans, or insurance plans with specific access requirements are responsible for understanding and complying with all of their insurance plan requirements, including referrals, authorizations, non-covered benefits, and other 'network' restrictions. The Hospital will request any necessary pre-approval, authorization, or guarantees of payment from the insurer whenever possible. Under some circumstances, including Emergency or Urgent Services, these referrals and authorizations may take place after service delivery. All patients who incur a balance for services will be informed of the availability of financial assistance to assist them in fulfilling their financial responsibility to Hallmark Health.

### B. Preparation of Estimates

Upon request by a patient prior to the delivery of a Non-Emergency, Non-Urgent Service, the Hospital shall provide an estimate of the allowed amount or charge for the service including the amount of any facility fees. The estimate information is gathered and then calculated generally by the Hospital using historic average allowed amounts or charges based on the projected medical or surgical service and, if applicable, estimated length of stay. To the best of the Hospital's ability, estimates will take into account patient responsibility, including co-payments, deductibles, and co-insurance. Estimates do not take into account all services delivered and billed by the organizations listed in [Appendix B](#). Final balances may differ from the estimate provided to the patient due to extenuating circumstances which may require more complex procedures, exams, and/or evaluations. Estimates require the participation of the patient and the treating clinician to reasonably identify expected future treatment and clinical care. Once the clinical services necessary to base the estimate upon are identified, the Hospital has two (2) business days from the date of

request to finalize the estimate and respond to the patient. The final estimate is provided to the patient along with payment options.

**C. Insured Patients**

The Hospital will make diligent efforts to verify the patient's insurance status and assist the patient in complying with the requirements of their health insurance plan. Patients are responsible for obtaining referrals from other providers, when required. Insurance verification will occur in accordance with the principles previously outlined in Section III above. Whenever possible, this verification will include a determination of the patient's expected financial responsibility, including applicable co-payments, deductibles, and co-insurance. Where feasible and clinically appropriate, payment of any predetermined amounts (co-payments, fixed deductibles) associated with a Non-Emergency, Non-Urgent service will be secured from the patient prior to or on the date of service. Where feasible and clinically appropriate, the Hospital may collect co-payments after a medical screening exam from an Emergency or Urgent patient. In some cases, the patient's insurance plan and type of coverage may not allow for an exact determination of the patient's financial responsibility prior to services being rendered. In those cases, the Hospital may request a deposit equal to its best estimate of the patient's expected financial responsibility. Patients who are unable to provide payment in advance of the receipt of any Non-Emergency, Non-Urgent service or following the receipt of an Emergency or Urgent service may be referred to Financial Counselors.

- 1) **Contracted Insurance Plans:** The Hospital contracts with a number of insurance plans. In those cases, the Hospital will seek payment from the insurance plan for all covered services. To assist patients with establishing their out-of-pocket costs, the Hospital shall, upon the request of the patient, provide sufficient information regarding the proposed Non-Emergency, Non-Urgent Service. If a particular service is determined by the insurer to be non-covered or otherwise rejected for payment, then payment for that service will be sought directly from the patient in accordance with the relevant insurance contract. Whenever possible, the Hospital will assist the patient in appealing denials or other adverse judgments with their insurance plan recognizing that the insurance plan often requires these appeals to be made by the patient.
- 2) **Non-contracted Insurance Plans:** The Hospital will extend the courtesy of billing a patient's insurance company in those cases where the Hospital does not have a contract with an insurer. While the Hospital will bill the patient's insurance plan, ultimate financial responsibility rests with the patient or guarantor (the party responsible for the patient's personal financial obligations). The insurer's failure to respond to the Hospital's bill in a timely manner may result in the patient being billed directly for the services except in those cases where the patient is protected from collection actions (Section IX(B)(6)). Balances remaining after any insurance payment will be billed to the patient. Whenever possible, the Hospital will assist the patient in appealing denials or other adverse judgments with their insurance plan recognizing that the insurance plan often requires these appeals to be made by the patient.

**D. Uninsured Patients (Self Pay)**

Patients who do not have health insurance, and have not been previously determined to be qualified as a "Low Income Patient" under the Massachusetts Health Safety Net (HSN) as further described in Section VI(F) below, will be asked to provide payment in full in those cases where an estimate of the charges is available. When an estimate is not available, a pre-determined deposit in advance of the receipt of any Non-Emergency, Non-Urgent services at the Hospital will be obtained. If the patient does not provide the pre-payment or indicates an inability to pay the deposit, then the patient may be referred to Financial Counselors.

Uninsured patients will be referred to Financial Counselors to determine their eligibility for available State and Federal programs, and if eligible, Financial Counselors shall assist such patient in applying for such programs. This includes Massachusetts residents applying via the Commonwealth of Massachusetts Health Connector. In addition to the potential availability of any government programs, all uninsured patients will be provided information on possible financial assistance programs available under the Hallmark Health Financial Assistance Policy (available at

<https://www.hallmarkhealth.org/Financial-Counseling-and-Billing/Financial-Assistance-Policies.html>, by calling to schedule an appointment with the Hospital's Financial Counselors at 781-338-7111.). If there is no immediate need to provide the services as determined by the treating clinician, the Non-Emergency, Non-Urgent service may be indefinitely postponed until such time as the patient is able to pay, make suitable financial arrangements, obtain insurance or become enrolled in a financial assistance program that will cover the service.

**V. PATIENT ACCOUNTS AND FINANCIAL COUNSELING SERVICES**

**A. Generally**

The Hospital will make diligent efforts to identify patients who may be uninsured or underinsured in order to provide counseling and assistance. The Hospital will provide financial counseling to these patients and their families, including screening for eligibility for other sources of coverage, such as Federal or State government programs, and providing information regarding all acceptable methods of payment of the Hospital bill. If additional financial assistance is required, the Patient Accounts department may extend discounts or other adjustments to patients if they qualify under the Hallmark Health Financial Assistance Policy. The patient has a number of responsibilities in order to qualify for assistance, including the obligation to submit all necessary and accurate documentation. Where patients may qualify for Federal programs, including Medicare, the Hospital will advise the patient of potential programs and assist with the application and documentation when appropriate.

**B. Communication of Financial Counseling Services**

The Hospital widely publicizes information about the availability of financial assistance programs, including where to go for assistance. Please reference Hallmark Health Financial Assistance Policy for additional details (available at <https://www.hallmarkhealth.org/Financial-Counseling-and-Billing/Financial-Assistance-Policies.html>).

**C. Residency**

Residency is a determinant of available financial assistance eligibility under the State, Federal, and Hospital financial assistance programs. Please reference Hallmark Health Financial Assistance Policy for additional details (available at <https://www.hallmarkhealth.org/Financial-Counseling-and-Billing/Financial-Assistance-Policies.html>).

**D. Hospital Financial Assistance, Discounts, Charity Care**

Patients are encouraged to first apply for State and/or Federal programs. If the patient is not eligible for these programs, financial assistance may be available under the Hallmark Health Financial Assistance Policy.

**E. Special Application Considerations**

- 1) Confidential Applications: Confidential applications for State or Hospital financial assistance programs may be submitted under two circumstances:
  - a. Minors: confidential applications for coverage may be submitted for minors presenting for family planning services and services related to sexually transmitted diseases. These applications may be processed under the minor's income without any regard to the family income. These patients should be referred to Financial Counselors.
  - b. Abused Individuals: these individuals may also apply for coverage on the basis of their individual income and are not required to report his/her primary address. These patients should be referred to Financial Counselors.
- 2) Undocumented Persons: Patients may be concerned about the immigration implications of applying for Low Income Patient status under the available State programs described in Section VI below. Patients with limited means to pay will be encouraged to apply for State or other government sponsored programs. Patients refusing to apply for assistance will continue to be treated as Uninsured and Urgent and Emergency Services will continue to be provided. Non-Urgent, Non-Emergency services may be indefinitely

postponed until such time as the patient is able to pay, make suitable financial arrangements, obtain insurance, or become enrolled in a financial assistance program that will cover the service.

## VI. STATE PROGRAMS – MASSACHUSETTS RESIDENTS

In addition to following the general procedures for Insured (Section IV(C)) and Uninsured (Section IV(D)) patients above, the Hospital will encourage patients who are potentially eligible for coverage from State Programs or other government programs to apply for coverage and may assist the patient in applying for benefits. Patients may also apply for and be approved for coverage by the HSN for co-insurance or deductibles not covered by their primary insurance plan; co-payments are excluded from this coverage. State programs a patient may be approved for include, but are not limited to, MassHealth, HSN, and other programs through the Health Connector (collectively, the “State Programs”).

### A. Application Process – All State Programs Other Than Medical Hardship

The Hospital assists the patient in completing the application for State Programs and securing and submitting the necessary documentation required by the applicable State Program. Individuals apply for coverage through the appropriate application that is submitted through the State’s enrollment system. The individual can submit an application through an online website, which is centrally located on the State’s Health Connector website, a paper application, or over the phone with a customer service representative located at either MassHealth or the Health Connector. Necessary documentation may include, but is not limited to proof of: (1) annual household income (payroll stubs, record of social security payments, and a letter from the employer, tax returns, or bank statements), (2) citizenship and identity, (3) immigration status for non-citizens (if applicable), and (4) assets of those individuals who are 65 and over. The State will notify the patient of any documentation that needs to be submitted for final verification. The patient may receive provisional coverage if the applicable program guidelines are met.

### B. Application Process – HSN - Medical Hardship

The Hospital will work with the patient to determine if a program like HSN- Medical Hardship would be appropriate. If so, the Hospital will assist the patient in completing and submitting a Medical Hardship application to the Health Safety Net. It is the patient’s obligation to provide all necessary information as requested by the Hospital in an appropriate timeframe to ensure that the Hospital can submit a completed application. Once a patient completes the application and assembles all of the required documentation, the Hospital shall submit the completed application to the HSN within five (5) business days of receiving it from the patient. If the completed application provided by the patient is not submitted by the Hospital within five (5) business days of receiving it from the patient, collection actions may not be taken against the patient with respect to bills that would have been eligible for Medical Hardship if the application had been submitted timely to the State.

### C. Approval for Coverage under State Programs

The Hospital may assist patients with applying for coverage under available State Programs but has no role in the determination of program eligibility made by MassHealth or the HSN. MassHealth or the HSN will issue all notices of eligibility. It is still the patient’s responsibility to inform the Hospital of all coverage decisions made to ensure accurate and timely adjudication of all Hospital bills.

### D. Effect of a Pending HSN/MassHealth Application

Patients for whom the Hospital has submitted a Massachusetts Health Connector application which covers MassHealth and HSN program eligibility will have bills held until such determination is made.

### E. Appeal of Outcome

- 1) MassHealth: The patient may take a direct role in appealing or seeking information from MassHealth related to their coverage decision. The request must be sent to MassHealth with supporting documentation.

- 2) Low Income Patient: An individual may request that MassHealth/the Connector conduct a review of the determination of Low Income Patient status, the Hospital's compliance with the provisions of 101 C.M.R. § 613.00, or, in exceptional circumstances, Medical Hardship eligibility.

**F. HSN – Low Income Patient Eligibility and Coverage Considerations**

- 1) Low Income Patient Determination  
Low Income Patient determination is made by MassHealth/Massachusetts Health Connector eligibility system and is limited to Massachusetts residents. A patient must submit an online or paper-based application as further described in Section VI(A) or Section VI(B) above to qualify including documentation required to establish Massachusetts residency, identity, and income. There are four main Low Income Patient coverage categories under the HSN: (i) HSN-Primary (Section VI(F)(4) below); (ii) HSN-Secondary (Section VI(F)(5) below); (iii) HSN-Partial (Section VI(F)(6) below); and (iv) HSN-Medical Hardship (Section VI(F)(7) below).
  - a. The Hospital may also assist patients with enrolling in the Health Safety Net using a presumptive determination process, which provides a limited period of eligibility. This process is conducted by Financial Counselors, who, on the basis of the patient's self-attestation of financial information, will deem a patient as meeting the Low Income Patient definition for coverage of Health Safety Net services only. Coverage will begin on the date that the Hospital makes the determination through the end of the following month in which the presumptive determination is made. However, coverage may be modified sooner if the patient submits a full application for State Programs as further described in Section VI(A) or Section VI(B) above.
- 2) Eligibility for HSN  
A patient's eligibility status for coverage under the HSN will be verified at time of registration using MassHealth Eligibility Verification System (EVS) system, Massachusetts's Medicaid Management Information Systems (MMIS), Passport, or other Hospital eligibility systems, as applicable, and any changes to the patient's status will be noted in the record.
- 3) Service Limitations  
Patients who are identified as Low Income Patients will, to the extent possible, be provided services consistent with the coverage guidelines of either HSN or MassHealth including "Eligible Service" limitations under state regulations and the applicable drug formulary. A patient seeking to receive a Non-Emergency, Non-Urgent reimbursable service will be informed in writing of the maximum cost of that service and must sign an acknowledgement that they accept financial responsibility prior to service delivery.
- 4) Coverage - HSN – Primary  
A Low Income Patient who is uninsured and documents MassHealth MAGI Household income or Medical Hardship Family Countable Income (as described in 101 C.M.R. § 613.04(1)), between 0-300% of the Federal Poverty Level (FPL) may be eligible for HSN - Primary subject to the following exceptions:
  - a. Low Income Patients eligible for the Premium Assistance Payment Program operated by the Health Connector are eligible for Health Safety Net - Primary only to the extent allowed under 101 C.M.R. § 613.04(5)(b).
  - b. Students subject to the Qualifying Student Health Plan requirement of M.G.L. c. 15A, § 18 are not eligible for Health Safety Net - Primary coverage.
- 5) Coverage -- HSN - Secondary  
A Low Income Patient may be eligible for HSN - Secondary if he or she has other primary insurance and documents MassHealth MAGI Household income or Medical Hardship Family Countable Income (as described in 101 C.M.R. § 613.04(1)) between 0-300% of the FPL, subject to the following exceptions:

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- a. Low Income Patients eligible for the Premium Assistance Payment Program operated by the Health Connector are eligible for Health Safety Net - Secondary only to the extent allowed under 101 C.M.R. § 613.04(4)(a)(2)(a).
  - b. Students subject to the Qualifying Student Health Plan requirement of M.G.L. c. 15A, § 18 are not eligible for Health Safety Net - Secondary coverage.
- 6) Coverage -- HSN - Partial Deductibles  
Patients that qualify for HSN - Primary or HSN - Secondary with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPL may be subject to an annual deductible if all members of the Premium Billing Family Group (PBFG) have an income that is above 150.1% of the FPL. A PBFG is a group of persons who live together as further defined in 130 C.M.R. § 501.001. If any member of the PBFG has an income that is below 150.1% of the FPL, there is no deductible for any member of the PBFG. The annual deductible is calculated in accordance with 101 C.M.R. § 613.04(4)(c)(1).
- 7) Coverage -- HSN - Medical Hardship  
A Massachusetts resident of any income level may qualify for Medical Hardship through the Health Safety Net if allowable medical expenses have so depleted his or her countable income that he or she is unable to pay for health services. To qualify for Medical Hardship, the applicant's allowable medical expenses must exceed a specified percentage of the applicant's Countable Income defined in 101 C.M.R. § 613.05(1)(c). The applicant's required contribution is calculated as the specified percentage of Countable Income as defined in 101 C.M.R. § 613.05(1)(b) based on the Medical Hardship Family's FPL multiplied by the actual Countable Income less bills not eligible for Health Safety Net payment, for which the applicant will remain responsible.
- 8) Low Income/ Partial HSN/Medical Hardship Patient Financial Responsibility:
- a. The financial responsibility for a Low Income Patient is limited to co-payments (from any payer except Medicare), deductibles determined by HSN (as discussed in Section VI(F)(6) above), or the patient has agreed to be billed for the CommonHealth Spend Down.
  - b. Deposits for Low Income Patients designated as Partial HSN (as discussed in Section VI(F)(6) above) or Medical Hardship (as discussed in Section VI(F)(7) above): Deposits will be requested from these patients provided this is the primary coverage for the open balances for all Non-Emergency, Non-Urgent medically necessary services. The current status of the Partial HSN patient's annual family deductible will be reviewed and a deposit of up to 20% of the patient's annual deductible up to a maximum of \$500 may be collected from the patient. The Hospital may also request a deposit from patients eligible for Medical Hardship of up to 20% of the patient's Medical Hardship contribution, up to a maximum of \$1,000.
  - c. Payment Plans: Low Income Patients will be notified of the availability of payment plans to satisfy all open balances per the terms specified in Section VIII Payment Arrangements.
  - d. Non-Medically Necessary Services: Low Income Patients will be required to pay for any Non-Medically Necessary Services as described in Section II(C), in advance, provided that the patient is informed of the maximum cost of these services in advance and signs an acknowledgement that the services are not covered by HSN or any other Massachusetts assistance programs. Services will be indefinitely postponed until payment is made in accordance with Section VIII(E).

## VII. NON-MASSACHUSETTS RESIDENTS

### A. Non-Massachusetts U.S. Residents

In addition to following the procedures stated for Insured (Section IV(C)) and Uninsured (Section IV(D)) patients, the Hospital will encourage non-Massachusetts U.S. resident patients who are potentially eligible for coverage under

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their own state Medicaid or other government programs (the Non-Massachusetts U.S. Resident State Programs) to apply for coverage.

- 1) The Hospital may assist Non-Massachusetts U.S. Residents applying for State Programs by providing the patient with information about the applicable programs. Individuals apply for coverage through the appropriate application that is submitted through the Non-Massachusetts U.S. Resident State's enrollment system. Necessary documentation may include, but is not limited to proof of: (1) annual household income (payroll stubs, record of social security payments, and a letter from the employer, tax returns, or bank statements), (2) citizenship and identity, (3) immigration status for non-citizens (if applicable), and (4) assets of those individuals who are 65 and over. The applicable state will notify the patient of any documentation that needs to be submitted for final verification.
- 2) The Hospital has no role in the determination of program eligibility made by Non-Massachusetts U.S. Resident State Programs. Those programs will issue all notices of eligibility, not the Hospital. It is still the patient's responsibility to inform the Hospital of all coverage decisions made to ensure accurate and timely adjudication of all Hospital bills.
- 3) The patient may take a direct role in appealing or seeking information from the Non-Massachusetts U.S. Resident State Program related to the coverage decision.

### **B. International Patients**

In addition to following the procedures stated for Insured (Section IV(C)) and Uninsured (Section IV(D)) patients, the Hospital will make every reasonable effort to gather local and permanent address information for residents of foreign countries and take whatever appropriate additional actions are needed in order to secure pre-payment for all Non-Emergency, Non-Urgent services.

## **VIII. PAYMENT ARRANGEMENTS**

### **A. Generally**

Payments may be made in a variety of settings at the Hospital. Different payment arrangements may be available including deposits (down payments) and payment plans. The patient or guarantor is able to make these arrangements with Hallmark Health Patient Accounts Customer Service. All payment arrangements will conform to pre-determined criteria and be recorded appropriately in the Hospital's billing and registration systems.

### **B. Forms of Payment**

Payments may be made by personal checks, certified/bank check, wire transfer, credit/debit cards, or cash. The Hospital will maintain a process to track "bad" checks and reverse any payments that may have been applied to the patient's account. Submission of a "bad" check may be grounds for transferring the account to Bad Debt.

### **C. Currency**

Unless otherwise agreed to, payment will be made in U.S. currency. Payment made in non-U.S. currency will be applied at the conversion rate specified by the Hospital's bank, including any conversion fees.

### **D. Payment Plans**

The Hospital maintains a separate Financial Assistance Policy that addresses payment plans. All Low Income or Medical Hardship Patients will be notified that the Hospital offers a payment plan. The Financial Assistance Policy is readily available to members of the public on the Hospital's website at <https://www.hallmarkhealth.org/Financial-Counseling-and-Billing/Financial-Assistance-Policies.html>.

**E. Deposits**

Hallmark Health reserves the right to request advance payment in full for patients who receive Non-Emergency, Non-Urgent services. If an estimated price is not available, patients will be required to provide a deposit (down payment toward future expected balance). Failure to pay in full in advance of the receipt of any Non-Emergency, Non-Urgent services or failure to meet the deposit requirement will result in indefinite postponement of the services provided the treating clinician determines that the procedure is not medically necessary. Hallmark Health will not require pre-admission and/or treatment deposits from individuals that require Emergency or Urgent Services or from individuals who are protected from such collection actions under applicable state laws (Appendix C - Patients Protected from Collection Action).

**IX. PATIENT BILLING AND COLLECTIONS**

**A. General Principles**

The Hospital will make diligent efforts to collect all charges that are due from insurers according to established industry standards and will seek to apply payments and contractual adjustments on a timely basis to the patient's account. These efforts include billing all available insurance plans according to the payers' requirements and timely follow up of denied claims. Patients or other guarantors will be held responsible for all account balances that remain after application of all insurance payments, contractual adjustments, and agreed upon discount/adjustments in accordance with any remittance advice received from the payer except where the balance may be submitted to the Health Safety Net or deemed exempt from collection activity under Massachusetts laws. Collection actions may include patient statements, patient letters, telephone contacts, certified final collection notices, and extraordinary collection activities including credit bureau reporting.

**It is the patient's obligation to provide complete and timely insurance and demographic information and to know what services are covered by their insurance policy. Patients who have the means are expected to pay for services rendered by Hallmark Health.**

**B. Hospital Billing Practices, including Patient Statements, Letters, and Calls**

The Hospital will make diligent efforts to ensure the appropriate party is billed and collection is made from the appropriate payer. The Hospital, either directly or through its designated agents, will prepare and mail statements to patients/guarantors on a regular basis to advise them of balances owed to the Hospital. A record of all account actions and communications, including bills, is typically reflected in the billing system. Staff is required to document all contacts with the patient (or guarantor) in the applicable billing system, registration system, or self-pay collection system. For Massachusetts residents, claims will not be submitted to Health Safety Net until after these diligent efforts are exhausted.

- 1) Initial Patient Bill: The Hospital will send an initial bill to the patient or the guarantor. The initial bill will have a summary of all charges, payments, and adjustments included with the initial billing for each date of service/admission. The initial bill will provide information about the availability of financial assistance programs that might be able to cover the cost of the Hospital's bill.
- 2) Subsequent Billing: The Hospital expects to continue billing the patient or guarantor approximately every 30 days for up to 120 days, which is the appropriate period of time representing continuous billing and collection actions.
- 3) Telephone Calls and other Communication: Telephone calls, billing statements, letters, personal contacts, notices, or any other notification method constitutes a genuine effort to contact the party responsible for the obligation and informs the patient of the availability of financial assistance.
- 4) Suspension of Billing: In certain situations, continued billing and collection activity may be inappropriate and may be suspended or discontinued. Such situations include, but are not limited to: Bad Address (Section IX(B)(9)), Bankruptcy cases (Section IX(D)(1)), patient grievance, small balances (Section IX(B)(10)),

## Hallmark Health Credit and Collection Policy

pending or approved MassHealth or HSN eligibility (Section VI(D) and Section IX(B)(6)), or patients who are in the process of applying for Hallmark Health Financial Assistance.

- 5) Notification of Availability of Financial Assistance: Patient statements will include notices as required by applicable laws to inform patients of the availability and means to access financial assistance. Notices regarding the availability of financial assistance will also be included in other written and verbal patient communications at intake and discharge.
- 6) Patients Protected From Collection Action: The Hospital will take reasonable steps to ensure that no collection actions, including telephone calls, statements or letters, are initiated for those patient balances that may be exempt from collection action under applicable laws. This may include patients enrolled in State Programs who are exempt from collection actions to the extent described in Appendix C, patients where the Hospital was delayed in submitting his/her Medical Hardship application (Section VI(B)), patients with a pending State Program application (Section VI(D)), or with a pending request for financial assistance under the Hallmark Health Financial Assistance Policy. The Hospital may continue to send letters requesting information or action by the patient to resolve coverage and/or eligibility issues with a primary payer, Worker's Compensation Program or to obtain any Third Party Liability or MVA carrier information.
- 7) Final (Collection) Notice: The Hospital will make reasonable efforts to send each patient a final (collection) notice by mail prior to the account being transferred to Bad Debt. Notices for patients who are minors will be sent to the guarantor.
- 8) Emergency Bad Debt for Massachusetts Residents: For those cases where an account is being considered by the Hospital for application to the HSN as Emergency Bad Debt, the Hospital will ensure the following conditions are met:
  - a. The account was subject to documented, continuous collection efforts for a minimum of 120 days;
  - b. An electronic eligibility inquiry was made to EVS or MMIS to screen for coverage;
  - c. The services provided qualify as Emergency Services per the definition in this policy; and
  - d. A final collection notice was sent by certified mail for balances of \$1,000 or more. Accounts that are properly documented as Bad Address accounts may be submitted to the Health Safety Net without the mailing of a final collection notice via certified mail provided that 120 days have elapsed from initial billing and that after a reasonable, genuine effort, the Hospital was unable to obtain an updated address.
- 9) Bad Address Returns: The Hospital will make reasonable efforts to track, research, and rebill all patient statements returned by the USPS that are not deliverable. Address information will be verified and corrected using "skip trace" programs that may be available from third parties. Where possible, accounts will be identified as "Bad Address" accounts in the billing and registration systems. Once an account has been flagged as Bad Address, no further statements or letters should be processed unless a new address has been identified. The Hospital will discontinue mailing of statements to incorrect addresses to maintain HIPAA privacy. Accounts whose most recent demographic information contains a Bad Address may be referred to outside agencies as Bad Debt for additional follow up except that potential Emergency Bad Debt accounts will be followed for 120 days prior to placement.
- 10) Small Balance Adjustment: Recognizing the cost of statement processing and collection activities, after the initial statement, the Hospital may suppress statements on accounts below its \$15 "small dollar billing" threshold. This policy shall be consistently applied across all payers. In no case will small balance adjustments taken under this section be billed to HSN.

**C. Surcharge Notice**

The Hospital will maintain a process to identify all patient balances that are subject to the Health Safety Net Trust Fund Surcharge on Acute Hospitals as required under 101 C.M.R. § 614.05. Surcharge amounts will be billed to the patient and the fund collected remitted to HSN per their requested schedule.

**D. Special Collections Situations**

- 1) Patient Bankruptcy: The Hospital will make reasonable efforts to track all Bankruptcy notifications, and maintain them on file to ensure that all approved court procedures are followed, including filing of claims with the Court as appropriate, or forgiveness of debt.
- 2) The Hospital will not bill a HSN Low Income Patient for (1) claims related to Serious Reportable Events as further described in 101 C.M.R. § 613.03(1)(d); or (2) claims due to an administrative or technical billing error.
- 3) HSN Secondary Coverage: The Hospital will make diligent efforts to limit claims submission to HSN, including deductibles and non-covered services, those cases where a patient has exhausted their benefit or in cases when enrollment with the payer was not active at the time the services were rendered. If the Hospital receives an additional or corrected payment on a claim previously submitted to HSN then a corrected claim will be submitted to HSN.
- 4) Partial HSN Deductible: The Hospital will bill patients for 100% of their annual Partial HSN Deductible minus any patient deposits obtained in accordance with Section VI(F)(8)(b) until charges equal to the annual deductible have been billed to the patient, inclusive of any balances included in payment plans. Claims will not be submitted to the HSN until the patient's deductible has been satisfied.

**E. Special Account Processing Considerations**

Under some circumstances, additional information or procedures may be necessary to properly process a patient's account.

- 1) Worker's Compensation (WC): Services related to industrial accidents should be appropriately labeled in the registration record. Additional information that is required includes the date and time of accident, employer name and phone number, and employer's worker's compensation carrier and phone number. The Hospital will make reasonable attempts to pursue the WC coverage. Any recoveries that may be received after the submission of a claim will be offset against the original claim and reported to the payer or HSN including any required claim voids or returns. If there is no WC coverage, then the claim is managed in the ordinary billing manner.
- 2) Motor Vehicle Accidents (MVA) and Third Party Liability (TPL): Services related to a motor vehicle accident or other third party liability should be appropriately labeled in the registration record. Diligent efforts will be made to collect additional information that is required for submission of MVA claims including the date and time of accident, the location for third party liability cases, and any known automobile insurer. The name of any attorney associated with the claim should also be noted in the registration system if it is available. Reasonable efforts will be made to bill the MVA/TPL carrier to collect any Personal Injury Protection (PIP) amount available. Health insurance claims will be processed after the PIP is exhausted. The Hospital may also file a lien against future bodily injury payments made by the MVA carrier to the patient if we are able to establish the name of the patient's attorney managing the claim. Any recoveries that may be received after the submission of a claim will be offset against the original claim and reported to the payer or HSN including any required claim voids or returns. If there is no MVA/TPL coverage, then the claim is managed in the ordinary billing manner.

## Hallmark Health Credit and Collection Policy

- 3) Health Insurance Portability and Accountability Act (HIPAA): Under HIPAA, patients who have paid the Hospital in full for a specific item or service have the right to request that their PHI (Protected Health Information) regarding such item or service not be sent to their health insurance plan for purposes of payment unless such disclosure is otherwise required by applicable law. Such restriction only applies to the specific item or service delivered and billed by the Hospital. Patients that wish to exercise such restriction are expected to pay any outstanding balance in full at the time of service or, if the balance cannot be fully estimated at the time of service, upon receiving statements. If the Hospital is unable to secure payment in full from the patient requesting such restriction after reasonable efforts, the Hospital may notify the patient and bill the patient's health plan. Accounts should be noted per procedure to guard against inappropriate release.

### X. BAD DEBT PLACEMENT

#### A. Transfer of Account to Bad Debt

The Hospital will make a reasonable effort to qualify a patient for financial assistance under State, Federal or Hallmark Health programs by notifying the patient in writing about the available assistance programs and assisting such individual with the completion of the applications. Once such reasonable efforts have been made and all internal collection efforts exhausted, accounts may be transferred to Bad Debt. This will typically occur after the account has completed its 120 day patient billing cycle with some exceptions due to Bad Address or other mitigating circumstances. Accounts in Bad Debt will generally receive additional collection efforts through a number of sources including staff, external collection agencies, or collection attorneys in accordance with applicable laws.

#### B. Collection Agencies

Any agency seeking to collect patient balances on behalf of the Hospital will be required to conform to this policy, including the obligation to refrain from "extraordinary collection activities" (as defined below) until such time as the Hospital has made a reasonable effort and followed a reasonable process for determining that a patient is entitled to assistance or exemption from any collection or billing procedures under this policy. Any substantive patient complaints will be reported to the Hospital for review and tracking. All agents will fully comply with applicable IRS and Federal Fair Debt Collection regulations as well as debt collection regulations under Massachusetts laws. All agencies will report any collection or other account actions, including the decision to cease collection efforts, on a timely basis.

#### C. Extraordinary Collection Actions (ECAs)

The Hospital may initiate Extraordinary Collection Actions (ECAs) in certain circumstances for accounts on which expected payment has not been made after reasonable efforts as defined in Section X(B).

- 1) Credit Reporting: The Hospital or a collection agency, on behalf of the Hospital, may report outstanding balances to credit bureaus.

### XI. CREDIT BALANCES AND REFUNDS

Generally, the Hospital will refund to patients any credit balances, which may result from excess funds having been collected from the patient. In cases where efforts to refund a self-pay credit balance are unsuccessful, the Hospital will remit credit balances to the Treasurer of the Commonwealth of Massachusetts in accordance with the state's Abandoned Property regulations.

### XII. SERIOUS REPORTABLE EVENTS (SREs)

The Hospital maintains compliance with applicable billing requirements, including the Department of Public Health's regulations (105 C.M.R. § 130.332) for non-payment of specific services or readmissions that the Hospital determines were the result of a Serious Reportable Event (SRE). SREs that do not occur at the Hospital are excluded from this determination of non-payment.

## Hallmark Health Credit and Collection Policy

### **XIII. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

The Hospital also maintains all information in accordance with applicable federal and state privacy, security, and ID theft laws.

### **XIV. PATIENT RIGHTS AND RESPONSIBILITIES**

The Hospital shall inform patients of their obligation to:

- 1) Provide complete and timely insurance and demographic information. Inform the Hospital and MassHealth of any changes in status including changes in income or insurance status, and tracking HSN manual deductible data.
- 2) Make reasonable efforts to understand the limits of their insurance coverage including network limitations, service coverage limitations and financial responsibilities due to limited coverage, co-payments, deductibles, and co-insurance.
- 3) For patients who have the means, pay for services rendered by Hallmark Health, including co-payments, deductibles, and co-insurance, in a timely manner.
- 4) Conform with insurance referral, pre-authorization, and other medical management policies. Conform with other insurance requirements including completion of coordination of benefits forms, updating membership information, updating physician information, understanding benefit coverage, and other payer requirements. For non-coverage of select medical services, acknowledge and arrange for alternative payment.
- 5) For Massachusetts residents, obtain coverage through the Health Connector, other sources of insurance, or apply for MassHealth/Commonwealth Care/Low Income Patient determination (if potentially eligible), including submission of all required documentation.
- 6) Notify the Hospital, of any potential Motor Vehicle Accident coverage, Third Party Liability coverage, or Worker's Compensation coverage. For patients covered by MassHealth or the Health Safety Net, file a claim for compensation, if available, with respect to any accident, injury or loss and notify the state public program (e.g. Office of Medicaid and the Health Safety Net) within ten days of information related to any lawsuit or insurance claim that will cover the cost of services provided by the Hospital. A patient is further required to assign the right to a third party payment that will cover the costs of the services paid by the State or the Health Safety Net or repay the HSN from the funds received from the third party. If the patient does not voluntarily repay the HSN from funds received from the third party, the HSN may recover such payments.

### **XV. PUBLICATION OF CREDIT AND COLLECTION POLICY**

The Hallmark Health Credit & Collection policy, Provider Affiliate List, and Hallmark Health Financial Assistance Policy are available at: <https://www.hallmarkhealth.org/Financial-Counseling-and-Billing/Financial-Assistance-Policies.html>.

- 1) This website may also be accessed from the Hallmark Health homepage (<https://www.hallmarkhealth.org/>) by selecting Patient/Visitor → Financial Counseling and Billing → Financial Assistance Policies.
- 2) The website includes various ways in which patients can apply for assistance from the Hospital, including a list of Financial Counseling locations and a central scheduling phone number. The website lets patients know that the application forms and Financial Counseling assistance are free.

### **XVI. BOARD APPROVAL**

The Hallmark Health Credit and Collection Policy was approved by the Hallmark Health Board of Trustees on July 27, 2017.

## Appendix A– Hallmark Health Locations, Participating Entities

This financial assistance policy applies to the services delivered and billed by Hallmark Health at the following locations:

1. Melrose-Wakefield Hospital Campus, 585 Lebanon Street, Melrose, MA 02176.
2. Lawrence Memorial Hospital Campus, 170 Governors Avenue, Medford, MA 02155.
  - a. Lawrence Memorial Hospital Urgent Care Center, 170 Governors Avenue, Medford, MA 02155.
3. Hallmark Health System Hematology and Oncology Center, 41 Montvale Avenue, 3rd, 4th, and 5th Floors, Stoneham, MA 02180.
4. Hallmark Health at 101 Main, 101 Main Street, Medford, MA 02155
  - a. Lawrence Memorial Hospital Rehabilitation Services, Suites 105 and 106.
  - b. Community Counseling Services, Suite 112.
  - c. Lawrence Memorial Medical Services, Suites 113, 114, and 116.
  - d. Family Medical Associates, Suites 213, 214, and 215.
5. Community Counseling Center, Malden Family Health Center, 178 Savin Street, 2nd Floor, Malden, MA 02148.
6. Health Image Women's Imaging Center, 830 Main Street, 3rd Floor, Melrose, MA 02176.
7. Chem Center for Radiation Oncology & MRI, 48 Montvale Avenue, Stoneham, MA 02180.
8. Hallmark Health Outpatient Diagnostic Testing and Rehabilitation Center, 30 Newcrossing Road, Reading, MA 01867.
  - a. Reading Urgent Care Center, 30 Newcrossing Road, Reading, MA 01867.
9. Melrose-Wakefield Hospital Rehabilitation Services, 22 Corey Street, Melrose, MA 02176.

## Appendix B: Hallmark Health Provider Affiliate List, Non-Participating Entities

Each of these providers or provider groups deliver services at a hospital location, however, their bills and charges are not covered under the Hallmark Health Financial Assistance Policy ("FAP"). The Hallmark Health FAP excludes services delivered and billed by the following entities associated with Hallmark Health:

1. Hallmark Health's Physicians Organization, Hallmark Health Medical Associates.
2. Hallmark Pathology, P.C.
3. Hallmark Imaging Associates, P.C.
4. Departments where a patient may be seen by a Provider not covered by the FAP are: Cardiology, Endocrine, Gastroenterology, Radiology/Hematology/Oncology, Infectious Disease, Internal Medicine, OB-GYN Care, Nephrology, Podiatry, Pulmonary, Rheumatology, Sleep Medicine, Surgery, Urology, Wound Care.
5. Melrose-Wakefield Emergency Physicians, Inc.
  - a. Physicians at Hallmark Health Emergency Departments located at Lawrence Memorial Hospital at 170 Governors Avenue, Medford, MA 02155 and Melrose-Wakefield Hospital at 585 Lebanon Street, Melrose, MA 02176.
  - b. Physicians at Hallmark Health System Urgent Care Centers located at 170 Governors Avenue, Medford, MA 02155 and 30 New Crossing Road, Reading, MA 01867.
6. Hospital Medicine Associates (Team Health).
  - a. Hallmark Health hospitalists located at Lawrence Memorial Hospital at 170 Governors Avenue, Medford, MA 02155 and Melrose-Wakefield Hospital at 585 Lebanon Street, Melrose, MA 02176.
7. Metropolitan Anesthesia.
8. Mystic Cardiology Associates, Inc., including Dr. Conway, Dr. Pladziewicz, and Dr. Samenuk.
9. Mystic Medical Group, including Dr. Weinstein.
10. UMS New England Lithotripsy.
11. Middlesex Cardiology Associates, Inc.
12. Tufts Medical Center Physicians Organization, Inc. (f/k/a New England Health Care Foundation, Inc.)
13. Eliot.
14. Pediatrix.
15. Regional Home Care.

All physicians and physician organizations associated with Hallmark Health including the providers set forth above are encouraged, but not required, to follow the financial assistance policy of Hallmark Health.

**APPENDIX C – Hallmark Health Patients Protected from Collection Action<sup>1</sup>**

The following patients who receive medically necessary services from the Hospital are exempt from collection actions to the extent described below. Collection actions include any activity by which the Hospital or an agent of the Hospital requests payment for services from the patient, the patient’s guarantor, or a third party responsible for payment. Such activities may include preadmission or pretreatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts and activities of collection agencies and attorneys.

<b>Massachusetts Program</b>	<b>General Rule</b>	<b>Exceptions</b>
<b>MassHealth Patients</b>	Hospital cannot bill as long as patient is able to provide proof of participation.	<ul style="list-style-type: none"> <li>a. May bill for copayments and deductibles.</li> <li>b. May bill for patients who cannot provide proof of participation.</li> </ul>
<b>Emergency Aid to the Elderly, Disabled and Children (EAEDC) Patients</b>		
<b>Children’s Medical Security Plan (CMSP) Patients with MAGI income equal to or less than 300% FPL</b>		
<b>Healthy Start Program Patients</b>		
<b>Medical Hardship Patients</b>	Hospital cannot bill the patient for the portion of its bill that exceeds the Medical Hardship contribution. This includes patients who become eligible for Medical Hardship payment from the HSN and have a pending Emergency Bad Debt claim.	
<b>Low Income Patients</b>		
<b>All Low Income Patients</b>	Hospital cannot bill the patient for non-reimbursable health services that the patient has agreed to take financial responsibility for if: (i) the claim for the non-reimbursable health service related to a medical error, or (ii) if the claim was denied by the patient’s primary insurance due to an administrative or billing error.	<ul style="list-style-type: none"> <li>a. May bill the patient for non-reimbursable health services for which the patient has agreed to take financial responsibility.</li> <li>b. At the request of the patient, the Hospital may bill the patient in order to allow the patient to meet the one-time deductible associated with the CommonHealth program.</li> </ul>
<b>All Low Income Patients Except Dental-Only Low Income patients</b>	Hospital cannot bill for reimbursable health services for which the Hospital is receiving payments from the HSN.	<ul style="list-style-type: none"> <li>a. May bill for copayments and deductibles.</li> <li>b. May bill for eligible services rendered by the Hospital prior to the patient’s determination as Low Income by the State or after their Low Income status has expired or been terminated.</li> </ul>

<p><b>Low Income Patients with MassHealth MAGI income or Medical Hardship Family Countable income between 150.1% to 300% of the FPL</b></p>	<p>Hospital cannot bill the patient for the portion of its bill that exceeds the deductible.</p>	<ul style="list-style-type: none"> <li>a. May bill for pharmacy copayments.</li> <li>b. May bill for Partial HSN deductible.</li> <li>c. May bill for eligible services rendered by the Hospital prior to the patient's determination as Low Income by the State or after their Low Income status has expired or been terminated.</li> </ul>
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<sup>1</sup> See, Massachusetts Health Safety Net regulations at 101 C.M.R. § 613.08(3).



HHS-382

**Addressee**

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**Please make checks payable and remit to:**




**AMOUNT DUE:**

Please complete the appropriate sections and return in the enclosed envelope as soon as possible.

Change of Address			
Name (Last, First, Middle Initial)			
Address			
City	State	ZIP	
Telephone			

If Paying By Credit Card, Fill Out Below			
CHECK CARD USING FOR PAYMENT <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> 			
CARD NUMBER			EXP. DATE
SIGNATURE			AMOUNT PAID
PRINT NAME			

Primary Insurance Updates			
Primary Insured Name			
Primary Insurance Name		Effective Date	
Primary Insurance Street Address			
City	State	ZIP	Telephone
Employer Name		Group Number	
Subscriber ID #		Policyholder's Date of Birth	

Secondary Insurance Updates			
Secondary Insured Name			
Secondary Insurance Name		Effective Date	
Secondary Insurance Street Address			
City	State	ZIP	Telephone
Employer Name		Group Number	
Subscriber ID #		Policyholder's Date of Birth	

**Explanation of Statement**

This statement is the summary on the unpaid balance of your account which is now your responsibility. Charges reflect only services rendered by Hallmark Health System.

**Contact Us:**

This billing statement represents only services rendered with current patient liability. If you are unable to pay your full balance at this time, please contact our business office to discuss alternative payment arrangements. If you have any questions, please call the Financial Services Department at 781-338-7000. Our office hours are Monday – Friday 8:00AM to 4:00PM. If you choose to contact us by mail, please include the patient name, account number, date of service and a description of the request; send your correspondence to:

Hallmark Health System  
 Attn: Patient Accounts  
 170 Governors Ave  
 Medford MA 02155

**Notice of Availability of Financial Assistance:**

The hospital provides financial assistance for medically necessary services for United States residents who cannot afford to pay based on the below Federal Poverty Guideline.

**Financial Assistance for Low Income Patients as of 2017**

For Financial Assistance Information for Hallmark Health System, Please Call: 781-338-7000

Size of Family Unit	Full Assistance up to these income levels	Partial Assistance up to these income levels
1	\$17,820.00	\$35,640.00
2	\$24,030.00	\$48,060.00
3	\$30,240.00	\$60,480.00
4	\$36,450.00	\$72,900.00

Alternative assistance may also be available through various public assistance programs, in cases of additional financial need or medical hardship.

**PLEASE CONTACT US IF YOU WOULD LIKE MORE INFORMATION.**