O South Georgia Medical Center

O Smith Northview Hospital
A Campus of South Georgia Medical Center

O SGMC Lanier Campus

O SGMC Berrien Campus

A Guide to Your Hospital Bill and Financial Policies

WHAT TO EXPECT AFTER RECEIVING SERVICES

Once services have been provided, all charges and diagnostic codes will be entered. You will receive a summary bill ten (10) days after services are rendered. This bill will summarize the charges entered on your account. This bill is for your information only. If you have provided insurance to be filed, it will be filed as soon as your account is complete. Once payment or denial is received, you will begin receiving monthly statements of the balance due. Please contact Patient Financial Services to establish payment arrangements or request financial assistance consideration so your account will not be subject to collection activities, including external collection and legal services. We are here to help. Please contact us before your account has been referred to collections.

YOUR BILL BECOMES DUE AT TIME OF DISCHARGE

South Georgia Medical Center (SGMC) will file a claim on your behalf (if appropriate), and make every effort to obtain payment from your insurance company or any third-party that might be responsible for your bill. However, as the patient or guarantor, ultimate responsibility for payment rests with you. Remember, your hospitalization coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for the payment of your account.

PATIENTS WITH INSURANCE

If you have insurance, you must present your insurance card or some other insurance identification upon registration or as soon thereafter as possible. SGMC will file your insurance claim for you. If you are receiving inpatient services, the hospital will obtain pre-certification on your behalf. If you are receiving outpatient services, you or your physician are responsible for obtaining necessary pre-certification. Regardless of who obtains pre-certifications, you are ultimately responsible for ensuring services are covered by your insurer.

PATIENTS WITH MEDICARE

If you have Medicare coverage, you must bring your Medicare card with you and sign the necessary forms at registration. SGMC will file your claim for you. You should be aware that Medicare will not cover your total bill. You are responsible for the deductible, co-insurance and certain other non-covered items.

PATIENTS WITH MEDICAID

If you have Medicaid coverage, you must bring your card with you and sign the necessary forms at registration. SGMC will file your claim for you. If you have applied for Medicaid, but have not been approved at the time of service, you must bring your Medicaid card to Patient Financial Services when you receive it so we can file your claim. If you would like to apply for Medicaid, a caseworker will be available to assist you with the application process.

PATIENTS WITHOUT INSURANCE

If you do not have sufficient medical coverage to pay for your hospitalization, the department of Patient Financial Services can assist you. Please ask to speak to a Patient Financial Services Account Representative if you have questions or concerns regarding balances owed at the time of discharge. You can contact a representative at (229) 333-1040 or call toll free 1 (877) 225-2071.

FINANCIAL POLICY

The financial policy of SGMC is designed to allow anyone in need of critical care and/or emergency health care to receive care regardless of financial status or of ability to pay. The policy also provides financial stability for SGMC, fairness to patients and third party and ensures that all patients who are financially able to pay their bills do so in a timely manner. SGMC's source of income for operating expenses is the income received from its patients; therefore, we ask for your cooperation in fulfilling your financial obligation. If you anticipate any difficulty regarding the financing of your hospitalization, or if you would like to apply for financial

assistance, please contact Patient Financial Services at (229) 333-1040 or toll free (877) 225-2071.

FINANCIAL ASSISTANCE PROGRAMS

SGMC provides free or reduced-cost care for patients who qualify according to the hospital's financial policies. Eligibility is based upon the patient's household income and family size. In most cases, you may be approved within 48 hours of application. If you have any questions, please contact Patient Financial Services.

Reasons patients could be denied financial assistance:

- Your income exceeds the income requirements noted in the guidelines of the SGMC Financial Assistance Policy;
- You fail to provide the required information

Services that will not be covered:

- Cosmetic surgery
- Physician services such as radiology, anesthesia, emergency room physicians, or any private provider. For these services, you will need to make private/separate payment arrangements.
- Non-medically necessary services, without extenuating circumstances.

If you feel you may be eligible for SGMC Financial Assistance and would like to apply, please provide the following:

- Completed Financial Statement
- Proof of Income: 3 months of most recent paycheck stubs and bank statements for all accounts, IRS W-2 for prior year, copy of IRS Form 1040 from prior year, written statements for most recent 3 months for other income (e.g. unemployment compensation or denial letter, disability, retirement, student loans, award letter from Social Security Office, current profit and loss report for all self-employed applicants, alimony and child support documentation, worker's compensation, etc.), food stamps letter
- Proof of Identity*
- Proof of Residency*
- Proof of number of dependents (household members)*

*Please reference the SGMC Financial Assistance Policy at www.sgmc.org for a complete list of all acceptable documents.

SGMC offers all patients the opportunity to apply for financial assistance, whether in the form of monthly payment arrangements or uncompensated care services.

If you apply and are approved for a payment plan, we will notify you as to your monthly payment terms. If you apply and are approved for uncompensated services, we will notify you if a portion or your entire hospital bill is covered.

A Financial Statement will not be considered if it is **not filled out completely and/or you do not provide proof of income**.

Upon receipt of this information, you have ten (10) days to return the completed financial statement with proof of income. If you have any questions regarding the application process, please call Customer Service during our normal business hours of 8 a.m. to 5 p.m. Monday through Friday.

INDIGENT CARE TRUST FUND

SGMC participates in the Indigent Care Trust Fund program. Our financial assistance policies are based upon ICTF guidelines. For more information, contact Patient Financial Services at (229) 333-1040 or 1 (877) 225-2071.

Patient Financial Services
Customer Service
(229) 333-1040 or 1 (877) 225-2071
Mailing Address:
South Georgia Medical Center
Patient Financial Services
P O Box 0070
Valdosta, GA 31603-0070

Financial Statement

Instructions:
1. *Please Print*
2. *Form must be complete, no blanks*
3. *Attach copies of the most recent income verification (i.e. tax return, check stub(s), direct deposit notice)*
4. *Sign and date application*

TOTAL AMOUNT OWED:

PATIENT NAME:	BIRTHDATE:	ADMISSION DATE (EXPECTED DATE IF PRE-ADMIT):
STREET ADDRESS:		P.O. BOX:
CITY, STATE, ZIP:	HOME PHONE NUMBER:	HOW LONG AT PRESENT ADDRESS?
TOTAL IN HOUSEHOLD (AS DEFINED BY IRS AND CLAIMED AS DEPENDENTS):		

LIST ASSETS: (Boat, CD's, Stocks, etc.)

DESCRIPTION / ACCOUNT NUMBER	ESTIMATED VALUE	DESCRIPTION / ACCOUNT NUMBER	ESTIMATED VALUE

GUARANTOR NAME:		RELATIONSHIP TO PATIENT:
OCCUPATION OF GUARANTOR:	GUARANTOR'S SOCIAL SECURITY #:	SPOUSE'S SOCIAL SECURITY #:
NAME OF GUARANTOR SPOUSE:	EMPLOYER OF GUARANTOR:	PHONE NO.:
EMPLOYER ADDRESS:		MONTHLY EARNINGS:
EMPLOYER OF SPOUSE:	PHONE NO.:	MONTHLY EARNINGS:
OTHER INCOME (SOURCE) AND AMOUNT:		
NAME, ADDRESS & PHONE NO. OF NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU:		
PHONE NO.:	RELATIONSHIP:	

CREDIT INFORMATION

CREDIT CARD NAME	OWED	MONTHLY PAYMENT	OTHER MEDICAL DEBTS	OWED	MONTHLY PAYMENT
(1) CAR LOAN PAYMENT			(2) CAR LOAN PAYMENT		

HOME AND MONTHLY EXPENSES O RENT O OWN

RENT/MORTGAGE PAID TO:					MONTHLY PAYMENT:	
UTILITIES:	CABLE:	TELEPHONE:	CAR:	GAS:	FOOD:	OTHER:

I UNDERSTAND THAT BY SIGNING BELOW, I ATTEST THAT THE INFORMATION SUBMITTED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. FURTHER, THE UNDERSIGNED CONSENTS TO INQUIRIES INTO HIS/HER CREDIT HISTORY INCLUDING OBTAINING A CREDIT REPORT FROM A CREDIT REPORTING AGENCY.

DATE:	APPLICANT (PLEASE PRINT):	SIGNATURE OF APPLICANT:
DATE:	GUARANTOR (PLEASE PRINT):	SIGNATURE OF GUARANTOR: