Village Ambulance Service, Inc.
Transport Billing Hardship Policy

PURPOSE:

To establish a policy that allows the modifying of ambulance transport fees based on current year Department of Health and Human Service Poverty guidelines, and to abide by decisions made by the Center for Medicare Medicaid Services (CMS) OIG.

SCOPE:

This policy pertains to all patients transported by Village Ambulance Service.

Transported individual must **NOT** have been injured while involved in the commission of a felony criminal activity.

Each resident as defined above may request one (1) hardship modification per consecutive twelve (12) month period.

PREFACE:

The charges for transport billing may be modified, based upon financial hardship, as determined by Village Ambulance Service. These procedures will ensure just and fair evaluation of a hardship waiver request as well as establish an audit trail for future use.

PROCEDURES:

1. No one will EVER be denied necessary medical transport service due to either their inability to pay or a lack of insurance.

2. Village Ambulance Service will address cases of financial hardship on an individual basis.

3. Patients who are unable to pay their co-pays, deductibles, or who are uninsured, unemployed, homeless, or for other reasons unable to make payments may request a financial hardship review of their transport charge. Patients, or their designee, shall complete the "Request for Transport Fee Hardship Fee Form" The form is available on the Village Ambulance Service website under the COMMUNITY link or can be requested by calling the Village Ambulance Service billing office at 413-458-4889.

4. The General Manager and Office Manager for Village Ambulance Service will make a final decision that will be noted on the form. The General Manager and Office Manager for Village Ambulance Service may waive all charges, reduce the charges, establish a payment plan or deny the request. All final resolutions will be noted on the form.

If approved for modification a copy of all documentation will be made and it will be held in the ambulance service files for a period of seven years. The original form will be transmitted to the billing company authorizing the elimination of the patient's charges. Village Ambulance Service will notify the patient in writing as to the final disposition of the Hardship Waiver.

Village Ambulance Service, Inc.

EMS TRANSPORT BILLING HARDSHIP PROGRAM

THIS HARDSHIP APPLICATION MUST BE SUBMITTED FOR EACH EMS TRANSPORT FEE ADJUSTMENT REQUEST

Applicant Name_____

SNN_____

Applicant Address _____

Date of Transport: _____

Monthly Household Gross Income:_____ Number of dependents living in household:_____

Attached documentation:
_____ W-2 withholding statements or unemployment check stubs for past 90 days
_____ Paycheck stubs for the past 90 days for all persons employed in the home
_____ Income tax return (most recent signed)
_____ Any other information you wish to provide that will help in our decision making process

Responsible Party (if different from applicant)

Name: _____Relationship:_____

Address (if different from
applicant):_____

In your own words explain why you are requesting a Hardship Waiver:
_____

_____

_____

_____

_____

_____

_____

_____

I do herby request that I, as either the applicant, or the party who is financially responsible for the applicant, be considered for a reduction in the payment responsibilities as they relate to this transport service fee. **By signing this form I certify that I have no insurance that can be billed for this charge. I declare that all of the information contained in this document and the attachments are true and accurate. Further I understand that I may be held liable for any false statements pertaining to this waiver request.** I herby agree to notify Village Ambulance Service of any change in the financial status of the applicant or the responsible party that may affect the ability to pay the Transport Fee.

Signature: _____Date:_____

Print Name: _____

For questions regarding the hardship waiver process call 413-458-4889 or via e-mail to billing@villageambulance.com

Mail this application and all attachments to:
Village Ambulance Service
30 Water Street
Williamstown, MA 01267

Administrative Use Only

Incident #:_____ Invoice Number: _____

Date of transport: _____

Date request received: _____

Claim: (circle) Approved Denied

Reason: _____

Date Billing Company Notified: _____/_____/_____

General Manager Approval Signature: _____

Office Manager Approval Signature: _____