THE WRIGHT CENTER FOR PRIMARY CARE

SHAPING THE FUTURE OF HEALTHCARE

Dear Patient,

Our records indicate that you were seen by a provider of the Wright Center Medical Group and you did not have any medical insurance coverage for the services provided.

If you have medical coverage, please call the Billing Department at 570-343-2383, Option #4 with your insurance information and we will update your file and submit these charges.

If you do not have medical coverage or have a balance after insurance, you may qualify for the sliding fee discount program. Eligibility is based on family (or household) income and size. To determine if you are eligible, you must first apply for Medical Assistance. If you are approved by Medical Assistance, we ask that you contact the Billing Department at the phone number above with this information. If you are denied by Medical Assistance, please complete the enclosed application and submit it along with the Medical Assistance denial letter and proof of income for each member of your household. Examples of income proof are most recent federal income tax return, W-2, last 3 paystubs, social security benefit statement, etc. Please send your application to:

The Wright Center Medical Group
501 Madison Avenue
Scranton, PA 18510
Attention: Linda Beck

You may contact me at 570-591-5148 with any questions.

Thank you for your prompt response.

Linda Beck
Financial Counselor

APPLICATION FOR MEDICAL SLIDING FEE DISCOUNT

You will be required to provide proof of income in order to qualify for the sliding fee.

Patient Name: _____Date of Request: _____
Last First Middle

Address: _____

_____
City State Zip Code

Phone Number: (cell) _____ (home) _____

Number of household members living at the above address _____

HOUSEHOLD MEMBERS (Any person, including yourself, living in household must be listed below):

Name Date of birth

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

HOUSEHOLD INCOME (List ALL household income for all adult household members):

	Total for 12 months
Gross Wages, Salaries, Tips	$_____
Social Security	$_____
Farm or Self-Employment	$_____
Public Assistance	$_____
Workers' Compensation	$_____
Alimony	$_____
Child Support	$_____
Military Family Pensions	$_____
Pensions	$_____
Dividend or Interest Income	$_____

Rental Income $_____
Other _____ $_____

Total $_____

PROOF OF INCOME IS REQUIRED FOR EACH ADULT MEMBER OF HOUSEHOLD.

Does patient currently have any medical insurance? Yes_____ No _____
If yes, please complete the following information: (medical)
Name and Address of Insurance: _____
Policy Number: _____
Policy Holder's Name: _____Date of Birth: _____

Does patient currently have any dental insurance? Yes_____ No _____
If yes, please complete the following information: (dental)
Name and Address of Insurance: _____
Policy Number: _____
Policy Holder's Name: _____Date of Birth: _____

Is patient receiving Medical Assistance*? Yes _____ No_____

***PATIENTS MUST APPLY FOR MEDICAL ASSISTANCE. IF DENIED FOR MEDICAL ASSISTANCE, A COPY OF THE REJECTION LETTER MUST BE SUBMITTED WITH THIS APPLICATION.**

Occupation of Patient: _____

Employer Name: _____

Employer Address: _____

If you had a change in financial circumstance since your last income tax return, please provide documentation of current income or financial status and write a note explaining how it has changed.

_____
_____
_____

I affirm that the above information is true and correct.

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient

For Office Use Only

This document was received on _____By _____

Rate approved per table_____ Reapply by _____