Banner Health

BANNER HEALTH (BH) 旗下所有医院的财务援助计划摘要
SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AT ALL HOSPITALS OWNED AND OPERATED BY BANNER HEALTH (BH)

Banner Health 为无保险、保险额不足和医疗贫困的患者提供财务援助计划。本政策适用于 Banner 医院和其他 BH 实体。无保险患者是指没有第三方保险且未投保政府保险计划的患者。无保险患者最初需按自费标准支付医保承保的服务费用。保险额不足患者是指拥有第三方保险、但有财务限制或共同责任（包括免赔额、共付额和共同保险额）的患者，且其自付费用超出其财务能力。医疗贫困患者是指在过去 12 个月内产生医疗费用的家庭，并且，其中家庭负责的费用部分超过该家庭当年总收入的 50%。在确定一个家庭是否为医疗贫困家庭时，所有医疗费用均将纳入考量，包括非 BH 医疗费用。

如果您是无保险的患者，并且，如果您不符合联邦贫困线指南的财务援助计划资格，您可能符合资格享受折扣费率。享受折扣医疗服务的资格是指，我们将向您收取 1.25 x AGB（一般账单金额），该金额基于在您已投保的情况下、私人医疗保险公司和 Medicare 针对您所获得的必要医疗服务本应向医院支付的金额之平均值（包括共付额和免赔额）。

如果您是无保险患者，在以下情况下，您将获得邦纳健康财政援助资格：（1）如果您的年度家庭收入和家庭规模等于或低于 400% 联邦贫困线，并且没有其他资产来支付医院的全额收费；并且（2）如经医院要求，您申请 Medicaid/AHCCCS，全面配合申请和决定流程，或者无法合理完成申请流程，并被 Medicaid/AHCCCS 拒绝。

如果您是保险额不足的患者，您可能有资格获得 BH 保险额不足/保险后余额财务援助折扣。您将需要申请以供审核，并满足财务援助政策和联邦贫困线指南中所述的医院账单余额要求。

如果您有资格获得 BH 财务援助，在任何情况下，向您收取的费用都不会超过紧急服务或其他医疗必要服务的一般账单金额。此外，您永远无需进行预付款或其他付款安排来接受紧急服务。但是，如希望获得非紧急服务，在大多数情况下，您需要根据一般账单金额的估计值支付大笔预付款或进行其他付款安排。

医院的财务援助政策、账单和催收政策以及申请表的免费副本可在 Banner Health 网站 Bannerhealth.com 上获取。本摘要的西班牙语翻译版本、医院的财务援助和账单政策以及申请表可在 Banner 和医院网站以及医院的入院区获取。此外，也可通过邮件获取副本；如有需要，请致电（888）264-2127 联系 Banner 患者财务服务部。Banner 患者财务服务部工作人员可以回答问题，并提供有关财务援助计划、申请流程以及可协助处理这些申请的非营利组织和政府机构的信息。如有任何疑问，请致电（888）264-2127。

Banner 患者财务服务部
PO Box 743711，Los Angeles，CA 90074-3711
BannerFAApplications@bannerhealth.com

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9999-0061ZH-CN
(04/2025)

Banner Health

SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AT ALL HOSPITALS OWNED AND OPERATED BY BANNER HEALTH (BH)

Banner Health offers Financial Assistance Programs to Uninsured, Underinsured and Medically Indigent patients. This policy applies to Banner hospitals and certain other BH entities. An Uninsured Patient means a patient without Third-Party Insurance and who is not enrolled in a government insurance program. Uninsured Patients are initially charged the Self-Pay Rate for Covered Services. An Underinsured Patient means a patient with Third-Party Insurance coverage, but with financial limitations or co-responsibility, including deductibles, co-payments, and co-insurance, has out-of-pocket expenses that exceed his/her financial abilities. A Medically Indigent Patient means a household with medical expenses incurred during the previous 12 months, where the portion for which the household is responsible exceeds 50% of the household's total income for that year. For the purposes of determining whether a household is a Medically Indigent Household, all medical expenses are included, including non-BH medical expenses.

If you are an Uninsured patient, you may qualify for a discounted rate if you do not meet the qualifications for the Financial Assistance Program based on Federal Poverty Level guidelines. Qualification for the discounted care means, you will be charged 1.25 x AGB (Amounts Generally Billed,) which is based upon the average of the amounts that would have been paid to the Hospital by private health insurers and Medicare (and co-pays and deductibles) for the medically necessary services you receive if you had been insured.

If you are an Uninsured patient, you will qualify for BH Financial Assistance (1) if you have an annual household income and household size that is equal to or less than 400% of the Federal Poverty Level and lack other assets to pay the Hospital's full charges and, (2) if requested to do so by the Hospital, you apply for Medicaid/AHCCCS, fully cooperate in the application and determination process, or are unable to reasonably complete the application process, and are denied Medicaid/AHCCCS coverage.

If you are an Underinsured patient, you may qualify for BH Financial Assistance for Underinsured/Balance After Insurance discount. You will need to apply for consideration and meet both Hospital bill balance requirements stated in the Financial Assistance Policy and Federal Poverty Level guidelines.

If you qualify for BH Financial Assistance, you will in no case be charged more than Amounts Generally Billed for emergency services or other medically necessary services. In addition, you will never be required to make advance payment or other payment arrangements to receive emergency services. However, to receive non-emergent services, you will be required in most situations to make a substantial advance deposit or other payment arrangements based upon an estimate of the Amounts Generally Billed.

A free copy of the hospital's financial assistance policy, the billing and collections policy, and the application forms are available on the Banner Health website at Bannerhealth.com. Spanish translation of this Summary, the Hospital's financial assistance and billing policies, and the applications forms are available on the Banner and Hospital websites and in the hospital's Admitting area. Copies are also available by mail by contacting Banner Patient Financial Services at (888) 264-2127. The Banner Patient Financial Services staff is available to answer questions and provide information about the Financial Assistance Programs, the application process and nonprofit organizations and government agencies that can assist with these applications. Please contact (888) 264-2127 if you have further questions.

Banner Patient Financial Services
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Banner Health

财务援助
计划及申请摘要

SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AND APPLICATION

请寄回至以下地址： Banner Health c/o PBM PO Box 743711，Los Angeles，CA 90074-3711 BannerFAApplications@bannerhealth.com	当前日期： 患者姓名： 出生日期： 设施： 服务日期：

说明：请填写申请表，包括以下文件，然后寄回至上述地址或电子邮件地址。

**不适用于 NHSC 地点，包括：Fallon，NV；Fernley，NV；Susanville，CA；Payson Primary Care，AZ；Payson OBGYN，AZ；Maricopa，AZ；Torrington， WY 和 Wheatland，WY。

- 收入证明。可接受的文件包括：
  - 如果目前有工作，请提供最近连续三（3）期的工资单复印件（适用于患者、担保人及配偶）。
  - 如果是自雇人士，请提供联邦税表 C 副本或其他收入和支出证明。
  - 如果已退休和/或领取社保，请提供 SSA 1099 表格或申领函的副本。**
  - 如果失业，请提供上一年度的联邦所得税申报表、失业补助申领函或收入自我申报函的副本。**
  - 州级或政府援助（Medicaid/AHCCCS）的认定书。**
  - 非 Banner 医疗账单的副本（如经要求）。**

申请信息

申请人/担保人姓名：_____ 社保号码：**_____

地址：_____

出生日期：_____

电话号码：_____

雇主：_____ 就业状况：_____

工作年限：_____ 失业日期/时长：_____

配偶或伴侣信息

姓名：_____

雇主：_____ 就业状况：_____

出生日期：_____

电话号码：_____

受抚养人和/或家庭规模信息

姓名：	关系：	出生日期：(mm/dd/yyyy)
1.		
2.		
3.		
4.		
5.		
6.		

收入说明：	每月金额：
1.	$
2.	$

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SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AND APPLICATION

Return to: Banner Health c/o PBM PO Box 743711, Los Angeles, CA 90074-3711 BannerFAApplications@bannerhealth.com	Current Date: Patient Name: Birth Date: Facility: Date of Svc:

Instructions: Complete application and include the following documentation and return to address or email above.

**Not applicable for NHSC locations including: Fallon, NV, Fernley, NV, Susanville, CA, Payson Primary Care, AZ, Payson OBGYN, AZ , Maricopa, AZ, Torrington, WY and Wheatland, WY.

- Proof of income. Acceptable documents include:
  - If currently employed, copies of last three (3) most recent consecutive payroll stubs (patient, guarantor and spouse)
  - If self-employed, a copy of Federal tax form Schedule C or other proof of income and expenses
  - If retired and/or receiving Social Security, a copy of SSA 1099 form or reward letter**
  - If Unemployed, a copy of your prior year's federal income tax return, unemployment reward letter or self-declaration of income letter.**
  - Determination of State or government assistance (Medicaid/AHCCCS)**
  - If requested, copies of non-Banner medical bills**

Applicant Information

Applicant/Guarantor Name:_____ Social Security Number:** _____

Address: _____

Birth Date: _____

Phone Number: _____

Employer: _____ Employment Status: _____

Length of Employment: _____ Unemployed Date/Length: _____

Spouse or Partner Information

Name: _____

Employer: _____ Employment Status: _____

Birth Date: _____

Phone Number: _____

Dependent and/or Household Size Information

Name:	Relationship:	Birthdate: (mm/dd/yyyy)
1.		
2.		
3.		
4.		
5.		
6.		

Income Description:	Monthly Amount:
1.	$
2.	$

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财务援助
计划及申请摘要
SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AND APPLICATION

请寄回至以下地址： Banner Health c/o PBM PO Box 743711，Los Angeles，CA 90074-3711 BannerFAApplications@bannerhealth.com	当前日期： 患者姓名： 出生日期： 设施： 服务日期：

医疗信息		
债务类型/债权人：	**未付余额：**	**月付款：**
1.（医生）	$	$
2.（医院）	$	$
3.（成像）	$	$
4.（DME/家庭护理）	$	$
5.（救护车）	$	$
6.	$	$

本人希望参加 Banner Health 的财务援助计划，并且，本人了解所有披露的个人信息仅用于确定本人的资格。Banner Health 会确保这些信息的安全和保密性。

据本人所知，本人所提供的信息准确无误。 已有人向本人解释且本人同意，作为本人符合资格获得 Banner Health 经济援助的条件，如果本人符合条件并领取援助，根据 ARS 第 33-931 条以及其他条款、亚利桑那州的医疗保健留置权或适用法规的规定，本人获得或有资格获得的任何第三方资金，均可由 Banner Health 酌情处理或取得，以用于抵消向本人提供的经济援助折扣。

责任方签名： _____ **日期/时间：** _____

正楷姓名： _____

配偶或伴侣签名： _____ **日期/时间：** _____

正楷姓名： _____

请寄回至以下地址：
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Medical Information		
Type of Debt / to Whom:	**Unpaid Balance:**	**Monthly Payment:**
1. (Doctor)	$	$
2. (Hospital)	$	$
3. (Imaging)	$	$
4. (DME/Home Care)	$	$
5. (Ambulance)	$	$
6.	$	$

I would like to participate in Banner Health's financial assistance program and understand all disclosed personal information is for the sole purpose of determining my eligibility. Banner Health will keep this secure and confidential.

The information I have provided is accurate to the best of my knowledge. It has been explained to me and I agree as a condition of my qualifying for financial assistance from Banner Health, should I qualify and receive assistance, any third-party funding I receive or become eligible to receive, pursuant to ARS Sec. 33-931, et seq., Arizona's health care lien statute, or applicable statutes, may be considered and recovered by Banner Health to address and offset the financial assistance discount provided to me.

Responsible Party Signature: _____ **Date/Time:** _____

Print Name:_____

Spouse or Partner Signature: _____ **Date/Time:** _____

Print Name: _____

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