Banner Health

BANNER HEALTH（BH）在所有醫院擁有和營運的 財務援助計畫摘要

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

Banner Health 為無保險、保險額不足及醫療貧困的患者提供財務援助計畫。本政策僅適用於 Banner 各個醫院以及其他 BH 實體無保險的患者是指沒有第三方保險且未加入政府保險計畫的患者。無保險的患者最初按承保服務的自付費率收費。保險額不足的患者是指具有第三方保險，但由於財務限制或共同責任（包括自負額、共付額和共同保險），其自付費用超出其財務能力。醫療貧困的患者是指在過去 12 個月內產生醫療費用的家庭，而該家庭應承擔的費用部分超過該家庭該年總收入的 50%。在判定一個家庭是否為醫療貧困家庭時，所有醫療費用都應納入考慮，包括非 BH 的醫療費用。

如果您是無保險的患者，且不符合基於聯邦貧困線指南的財務援助計畫資格，則您可能符合資格享受折扣費率。符合享受折扣醫療服務的資格是指我們將向您收取 1.25 x AGB（一般帳單金額）；該金額基於在您已投保的情況下，私人醫療保險公司和 Medicare針對您所獲得的必要醫療服務本應向醫院支付的金額（包括共付額和自負額）之平均值。

如果您是無保險的患者，您將在滿足以下條件時有資格獲得 BH 財務援助：（1）您的年度家庭收入與家庭規模等於或低於聯邦貧困線的 400%，且沒有其他資產可用於支付醫院的全額費用，且（2）如經醫院要求，您將申請 Medicaid/ AHCCCS，完全配合申請與決定流程，或因合理原因無法完成申請流程，並被 Medicaid/AHCCCS 拒絕承保。

如果您是保險額不足的患者，您可能有資格獲得 BH 保險額不足/保險後餘額財務援助折扣。您將需要申請以進行審核考慮，並滿足財務援助政策和聯邦貧困線指南中所述的醫院帳單餘額要求。

如果您有資格獲得 BH 財務援助，在任何情況下，向您收取的費用都不會超過緊急服務或其他醫療必要服務的一般帳單金額。此外，您永遠無需進行預付款或其他付款安排來接受緊急服務。但是，如希望獲得非緊急服務，在大多數情況下，您需要根據一般帳單金額的估計值支付大筆預付款或進行其他付款安排。

醫院的財務援助政策、帳單和追討政策以及申請表的免費副本可在 Banner Health 網站 Bannerhealth.com 上取得。如需本摘要、醫院財務援助和帳單政策以及申請表的西班牙語翻譯版本，可在 Banner 和醫院網站以及醫院入院區取得。此外，您也可透過透過致電 (888) 264-2127 洽詢 Banner 患者財務服務以郵寄紙本方式取得副本。Banner 患者財務服務部的工作人員可回答問題，並提供有關財務援助計畫、申請流程，以及可協助處理此類申請之非營利組織和政府機構的資訊。如有任何疑問，請致電（888）264-2127。

Banner 患者財務服務部
PO Box 743711, Los Angeles, CA 90074-3711
BannerFAApplications@bannerhealth.com

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0061ZH-TW
(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
PO Box 743711, Los Angeles, CA 90074-3711
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Banner Health

Banner Health（BH）
計畫與申請摘要

SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AND APPLICATION

請寄回至: Banner Health c/o PBM PO Box 743711, Los Angeles, CA 90074-3711 BannerFAApplications@bannerhealth.com	當前日期: 患者姓名: 出生日期: 設施: 服務日期:

說明：填寫申請表，並包括以下文件，然後寄回至上述地址或電子郵件地址。

**不適用於 NHSC 地點，包括：內華達州 Fallon、內華達州 Fernley、加利福尼亞州 Susanville、亞利桑那州 Payson Primary Care、亞利桑那州 Payson OBGYN、亞利桑那州 Maricopa、懷俄明州 Torrington 和懷俄明州 Wheatland。

- 收入證明。可接受的文件包括:
  - 如果目前有工作，請提供最近三（3）份最新的連續薪資單的副本（患者、擔保人和配偶）
  - 如果是自雇人士，請提供聯邦稅表附表 C 或其他收入和支出證明
  - 如果已退休和/或領取社保金，請提供 SSA 1099 表格或申領函的副本**
  - 如果失業，請提供上一年度的聯邦所得稅申報表、失業補助申領函或收入自我申報函的副本。**
  - 州級或政府援助（Medicaid/AHCCCS）的認定書**
  - 非 Banner 醫療帳單的副本（如經要求）**

申請資料

申請人/擔保人姓名: _____ 社會安全號碼: ** _____

地址: _____

出生日期: _____

電話號碼: _____

雇主: _____ 就業狀況: _____

工作年限: _____ 失業日期/時長: _____

配偶或伴侶的資料

姓名: _____

雇主: _____ 就業狀況: _____

出生日期: _____

電話號碼: _____

受撫養人和/或家庭人數資訊

姓名：	關係：	出生日期：（月月/日日/年年年）
1.		
2.		
3.		
4.		
5.		
6.		

收入描述：	每月金額：
1.	$
2.	$

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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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SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AND APPLICATION

請寄回至:	當前日期:
Banner Health c/o PBM PO Box 743711, Los Angeles, CA 90074-3711 BannerFAApplications@bannerhealth.com	患者姓名: 出生日期: 設施: 服務日期:

說明：填寫申請表，並包括以下文件，然後寄回至上述地址或電子郵件地址。

**不適用於 NHSC 地點，包括：內華達州 Fallon、內華達州 Fernley、加利福尼亞州 Susanville、亞利桑那州 Payson Primary Care、亞利桑那州 Payson OBGYN、亞利桑那州 Maricopa、懷俄明州 Torrington 和懷俄明州 Wheatland。

- 收入證明。可接受的文件包括:
  - 如果目前有工作，請提供最近三（3）份最新的連續薪資單的副本（患者、擔保人和配偶）
  - 如果是自雇人士，請提供聯邦稅表附表 C 或其他收入和支出證明
  - 如果已退休和/或領取社保金，請提供 SSA 1099 表格或申領函的副本**
  - 如果失業，請提供上一年度的聯邦所得稅申報表、失業補助申領函或收入自我申報函的副本。**
  - 州級或政府援助（Medicaid/AHCCCS）的認定書**
  - 非 Banner 醫療帳單的副本（如經要求）**

申請資料

申請人/擔保人姓名: _____ 社會安全號碼: ** _____

地址: _____

出生日期: _____

電話號碼: _____

雇主: _____ 就業狀況: _____

工作年限: _____ 失業日期/時長: _____

配偶或伴侶的資料

姓名: _____

雇主: _____ 就業狀況: _____

出生日期: _____

電話號碼: _____

受撫養人和/或家庭人數資訊

姓名：	關係：	出生日期：（月月/日日/年年年）
1.		
2.		
3.		
4.		
5.		
6.		

收入描述：	每月金額：
1.	$
2.	$

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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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