North Central Health Care
Person centered. Outcome focused.

FINANCIAL REVIEW

Name:_____________________________ **DOB:**____________ **MRN:**_________________

Consent Date: ______________________

Are any of your services covered by one of the following? If so, please check appropriate box(s) and complete the requested information.

MEDICARE: □ Yes □ No Medicare Number: ____________________________________

INSURANCE: □ Yes □ No

Subscriber Number: ________________________ Group Number: _____________________

Insured Name: ____________________________ Employer: _________________________

Insurance Company Name and Claims Address: ___________________________________

____

Insurance Effective Date: ______________ Telephone Number: _________________

MEDICAL ASSISTANCE: □ Yes □ No

Medical Assistance Number: _________________ Medical Assistance Effective Date: ______

If you answered yes to having Medical Assistance, please attach a copy of your card and *do not* complete the remainder of this form. If you *do not* have Medical Assistance and wish to apply for the payment schedule, please complete the rest of this application and return it **with your supporting documentation** to North Central Health Care, 1100 Lake View Drive, Wausau, WI 54403.

Client initials: __________

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YOUR GROSS MONTHLY INCOME: $____*(examples include: wages, Social Security, veterans and/or pension benefits, child support, alimony, unemployment and/or workers compensation, educational grants, interest, etc.)*

YOUR SPOUSE'S GROSS MONTHLY INCOME (if married): __________________________

MEMBERS OF HOUSEHOLD: ☐ Self ☐ Spouse

Number of Children under 18 Years *(dependents claimed)*_______

AMOUNT OF MEDICAL AND DENTAL BILLS PAID MONTHLY: $ ______________________

____
(also includes amount of prescription drugs paid monthly)

AMOUNT OF COURT ORDERED OBLIGATIONS: $________________ $________________

$________________ $________________ $________________ $________________

(list each obligation separately, include any child support payments you pay)

Client initials: __________

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Name:______________________________ DOB:____________ MRN:__________________

LIST ANY LIQUID ASSETS OVER $10,000.00 (only report if income is 200% or more above the Federal Poverty Level [FPL]): ____

____
(examples include checking accts, savings accts, CD's, money market certificates, stocks & bonds)

Please indicate current address and telephone number: ________________________________

____

PLEASE RETURN FORM WITH DOCUMENTATION

TO:________________________________ BY:____________________

I hereby affirm that the above information is true and correct to the best of my knowledge:

___________________________________	_________________	
Signature – Patient/Client	*Date/Time Signed*	
___________________________________	______________________	_________________
Signature – Parent/Guardian/Other	*Relationship*	*Date/Time Signed*