

Policy Title	Financial Assistance for Healthcare Services Policy	Policy ID	179
Keywords	patient, financial, assistance, charity, care, needed, services, NSA, Excluded, Financial Assistance Exclusions, FAA		

I. Purpose of Policy

To establish a policy for the administration of Dartmouth Health (DH) financial assistance for healthcare services program. This policy outlines the following with respect to all emergency or other medically necessary care provided by all DH facilities:

- eligibility criteria for financial assistance.
- method by which patients may apply for financial assistance.
- basis for calculating amounts charged to patients eligible for financial assistance under this policy and limitation of charges for emergency or other medically necessary care.
- DH's measures to publicize the policy within the community served.

This policy is intended to comply with the requirements of NH RSA 151:12-b, Internal Revenue Code Section 501(r) and the Patient Protection and Affordable Care Act of 2010 and will be updated periodically to the extent required by applicable law.

II. Policy Scope

This policy applies to any DH provider working in any DH facility responsible for providing emergency and any other medically necessary care and billed by a DH provider.

For purposes of this policy, "financial assistance" requests pertain to the provision of emergency and other medically necessary care provided in any DH facility by any provider employed by DH.

III. Non-Discrimination Statement

Dartmouth Health does not discriminate on the basis of race, color, sex, sexual orientation, gender identity, marital status, religion, ancestry, national origin, citizenship, immigration status, primary language, disability, medical condition, or genetic information in the provision of patient financial assistance or in the implementation of this financial assistance policy.

IV. Definitions

Financial Assistance (also known as "charity care"): The provision of healthcare services free or at a discounted rate to individuals who meet the criteria established pursuant to this policy.

Family is defined by the U.S. Census Bureau as a group of two or more people who reside together and who are related by birth, marriage, or adoption.

- The state law regarding marriage or civil union and the federal guidelines are used to determine who is included in a family.
- In the case of applicants who earn income by caring for disabled adults in their homes, the disabled adult will be counted as a family member and their income included in the determination.
- The Internal Revenue Service rules that define who may be claimed as a dependent for tax purposes are used as a guideline to validate family size in granting financial assistance.

Presumptive Financial Assistance: The provision of financial assistance for medically necessary services to patients for whom there is not a completed DH Financial Assistance Form due to lack of supporting documentation or response from the patient. Determination of eligibility for assistance is based upon individual life circumstances demonstrating financial need. Presumptive financial assistance is not available for balances after Medicare.

Household: A group of individuals primarily residing in the same household who have a legal union (blood, marriage, adoption), as well as unmarried parents of a shared child or children. A patient's household includes the patient, a spouse, a dependent child, unmarried couples with a mutual child dependent living under the same roof, same sex couple (married or civil union), and parents claimed on adult child's claim on a tax return.

Family Income: As defined under the federal poverty level (FPL) guidelines as published annually by the U.S. Department of Health and Human Services based on:

- earnings, unemployment compensation, Workers' Compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources
- noncash benefits (such as food stamps and housing subsidies) do **not** count
- pre-tax income
- the income of all family members (non-relatives, such as housemates, do **not** count).

Uninsured Patient: A patient with no insurance or other third-party source of payment for his/her medical care.

Underinsured Patient: A patient with some insurance or other third-party source of payment, whose out-of-pocket expenses nevertheless exceed his/her ability to pay in as determined according to this policy.

Gross Charges: The total charges at the organization's full established rates for the patient's healthcare services.

Emergency Medical Conditions: As defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd), a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- serious impairment to bodily functions

- serious dysfunction of any bodily organ or part
- with respect to a pregnant woman:
 - inadequate time to affect a safe transfer to another hospital before delivery.
 - a threat to the health or safety of the woman or the unborn child in the event of a transfer or discharge.

Medically Necessary: As defined by Medicare with respect to healthcare items or services, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Elective: Healthcare items or services which are not considered medically necessary.

Financial Assistance Exclusions: Services, which are not considered medically necessary or are considered elective. This policy applies to care provided by Dartmouth Health. These services are not covered by the DH Financial Assistance policy.

Dartmouth Health: For purposes of this policy Dartmouth Health System Members (DH) are Alice Peck Day Memorial Hospital, Cheshire Medical Center, Dartmouth Hitchcock Clinic, Mt. Ascutney Hospital and Health Center, New London Hospital, Mary Hitchcock Memorial Hospital, and Visiting Nurse and Hospice for Vermont and New Hampshire (VNH). All other hospitals in New Hampshire and Vermont are considered Non-Member facilities.

This policy applies to those DH member facilities using the Epic system.

V. Policy Statement

Dartmouth Health (DH), is committed to providing financial assistance to persons who have healthcare needs but do not have the financial means to pay for services or balances that are their responsibility.

DH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. A patient can apply for financial assistance any time before, during, and after service is provided, including after an account has been referred to an outside collection agency.

DH will provide care for emergency medical conditions and medically necessary services to individuals regardless of their ability to pay or eligibility for financial or government assistance, and regardless of age, gender, race, social or immigrant status, sexual orientation, or religious affiliation. In accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), no patient shall be screened for financial assistance or payment information prior to the rendering of services for emergency medical conditions.

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with DH procedures for obtaining financial assistance or other forms of payment, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance are required to do so, as a means of ensuring access to health care services, for their overall personal health, and for the protection of their individual assets.

DH will not impose extraordinary collections actions for any patient without first making reasonable efforts to determine whether that patient is eligible for financial assistance. Any exceptions must be approved by the Chief Financial Officer.

For information on actions DH may take in the event of nonpayment, please refer to our credit and collections policy. A copy of the Credit and Collection Policy is available online, can be requested at the Patient Financial Services Offices, or can be mailed to you by calling 844-808-0730.

A. Method by Which Patients May Apply for Financial Assistance

If there is no interaction with the patient concerning financial assistance, or the patient is unable to complete the application procedures required under this policy, such patients may nevertheless be considered for eligibility for presumptive financial assistance.

1. DH will explore alternative sources of coverage and/or payment from federal, state, or other programs and assist patients in applying for such programs. With respect to any balances remaining after such other sources have been exhausted, DH will conduct an individual assessment of a patient's financial need in order to determine whether an individual qualifies for assistance under this policy, using the following procedures:
 - A patient or guarantor is required to apply on a form approved by DH management, and provide such personal, financial, and other information and documentation as required for DH to determine whether such individual qualifies for assistance, including, but not limited to, documentation to verify Family Income and available assets or other resources. If DH is unable to obtain an application or any required supporting documentation from the patient or the patient's guarantor, DH may consider whether the patient is eligible for presumptive financial assistance.
 - In lieu of an application and supporting documentation from the patient, staff may use any of the following to support a recommendation for approval of a financial assistance application:
 - DH may utilize one or more vendors to screen individuals for eligibility using publicly available data sources that provide information on a patient's or guarantor's capacity and propensity to pay.
 - Current eligibility for Medicaid.
 - Current statement from a federal or state housing authority.
 - Verification from a homeless shelter or a Federal Qualified Health Center.
 - Verification of incarceration with no source of payment from the correctional facility.
 - For an individual patient, a patient's verbal attestation of income and assets, in lieu of a written income verification, may be accepted with respect to one (1) account only, provided that the balance on such account is less than \$1,000.
2. It is preferred, but not required, that a request for financial assistance and a determination of financial need occur prior to rendering non-emergent medically necessary services. However, a patient may be considered for financial assistance at any point in the collection cycle. An approved financial assistance application applies to all balances for which the patient has applied for charity, in addition to emergency

and other medically necessary care provided for a period, dates of service prior to receipt of the financial assistance application, including balances placed at a collection agency, and any services provided before or on the expiration date listed on the acknowledgement letter if the service is not listed below. After that time, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known, DH will re-evaluate the individual's financial need in accordance with this Policy.

DH recognizes decisions made by the following assistance programs without requesting copies of applications. DH reserves the right to accept or deny decisions made outside DH guidelines made by the organizations listed below. All applicable co-pays or other patient responsibility amounts should be requested in accordance with requirements of such programs.

- NH Health Access Network Card for insured patients only
 - Good Neighbor Health Clinics
 - Amoskeag Health
 - Lamprey Health
 - Mobile Community Health
 - Teen Health Clinic
 - Current Medicaid eligibility if not retroactive to cover past services
 - Deceased patient with no estate (as confirmed by executor or state)
3. It is the goal of DH to process a financial application and notify the patient of a decision in writing within 30 days of receipt of the completed application.
4. **Appeals Process:** If DH denies partial or total financial assistance, then the patient (or his/her agent) can appeal the decision within 60 days. The patient must write a letter to the Director of Eligibility and Enrollment to explain why the decision made by DH was inappropriate. The appeal letter will be reviewed by DH and a final decision will be sent to the patient within 30 days of the receipt of the request for appeal.

B. Eligibility Criteria for Financial Assistance –In order to qualify for financial assistance under this Policy, a patient must meet the following criteria:

- Be a resident of NH or VT, or a non-resident who receives emergency treatment at a DH facility.
- Be uninsured or underinsured, ineligible for any government health care benefit program, and unable to pay for their care as outlined in the Credit and Collections Policy, based upon a determination of financial need under this Policy.
- Have Gross Family Income, inclusive of all members of the patient's household, during the past 12 months of less than 400% of FPL.
- Have Gross Family Income at or below 600% of FPL and aggregate balances owed for services performed at DH in excess of 20% of one (1) years family income, including savings (see below).

- Savings (which includes savings accounts, alimony, or certificate(s) of deposit) are sheltered up to 400% of FPL.
- Demonstrate compliance with the requirements to apply for qualified health plan coverage in the New Hampshire or Vermont Healthcare Exchange Program if eligible for these programs. Exceptions to this requirement may be approved by senior leadership for good cause on a case-by-case basis. “Good cause” will depend on facts and circumstances, and may include:
 - Those that missed the open enrollment period and do not fall into a life changing event category outside of open enrollment.
 - Those for whom the financial burden will be greater for the patient to enroll in a qualified health plan than not to do so.

C. Determination of Amount of Financial Assistance

All insurance payments and contractual adjustments as well as the uninsured discount are taken prior to the financial assistance adjustment being applied. See DH Uninsured Patient Discount Policy: Revenue Management Division (linked below).

If an individual is approved for financial assistance, the amount of such assistance to be provided for applicable care will be as follows:

Insured patients: Insured patients shall have a discount applied to their out-of-pocket expenses.

For insured patients whose household income is at or below 250% of FPL, we will waive (i.e., 100% discount) all out-of-pocket costs for emergency and medically necessary services rendered (i.e., the care is free). For insured patients whose household income is:

- 251%-300% of FPL, the discount will be 75%
- 301%-350% of FPL, the discount will be 50%
- 351%-400% of FPL, the discount will be 40%

Uninsured patients: Uninsured patients who are eligible for financial assistance shall have a discount applied to the amount generally billed for the emergency and medically necessary services rendered.

For uninsured patients whose household income is at or below 250% of FPL, we will waive (i.e., 100% discount) the amount generally billed for emergency and medically necessary services rendered (i.e., the care is free). For uninsured patients whose household income is:

- 251%-300% of FPL, the discount will be 75%
- 301%-350% of FPL, the discount will be 50%
- 351%-400% of FPL, the discount will be 40%

In catastrophic situations, for uninsured or insured patients: If the total amount owed for emergency and medically necessary services rendered exceeds 20% of the household income, then the amount owed shall be reduced so that it is equal to 20% of the patient’s household’s income.

- Any discounts other than those described above must be approved by the Financial Assistance Appeals Committee based on a written appeal from the patient or responsible party.
- Patients meeting criteria for Presumptive Financial Assistance, will receive 100% financial assistance.
- Financial Assistance is effective for the following timeframes, based on the date of the application signature:
 - Working Family – Six (6) Months
 - Fixed Income Family – Twelve (12) Months
 - Unemployed Family – Three (3) Months
 - Out of State Residents – One (1) Month

Patients without insurance, including uninsured patients who qualify for financial assistance under this Policy, may not be charged any more than the amount generally billed to patients who have insurance covering the same care. Dartmouth Health applies a discount against gross charges to all balances for patients who have no insurance, resulting in a discounted balance which the patient is expected to pay.

The discount is based on the “look-back Medicare fee for service plus private payors” method as described under applicable regulations implementing Section 501(r) of the Internal Revenue Code. This discount is applied prior to billing the patient and prior to applying any financial assistance adjustments. This discount doesn’t apply to any copayments, co-insurance, deductible amounts, pre-payment or package services which already reflect any required discount, or to services classified as non-covered by all insurance companies.

For fiscal year FY26 -10/1/25 to 9/30/26, the following discount rates apply:

	FY24	FY25	FY26
Dartmouth-Hitchcock Clinic	64%	65.7%	69.4%
Mary Hitchcock Memorial Hospital	64%	65.7%	69.4%
Alice Peck Day Memorial Hospital	44.0%	45.8%	46.1%
Cheshire Medical Center	68.5%	70.8%	72.4%
New London Hospital	50.6%	53.8%	54.3%
Visiting Nurse and Hospice of VT and NH	0%	0%	0%
Mt Ascutney			44.8%

D. Communication Regarding the DH Financial Assistance Policy to Patients and Within the Community

- Referral of patients for financial assistance may be made by any DH staff member or agent, including physicians, nurses, financial counselors, social workers, case

managers, chaplains, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

- Information regarding financial assistance from DH, including but not limited to this policy, a plain language summary of this policy, an application form and information concerning DH's patient collection policies and procedures, will be available to the public and to DH patients through at least the mechanisms described below:
 - On the DH websites
 - Posted in patient care areas
 - Available on Information Cards in the registration and admitting departments
 - Available in other public spaces as determined by DH
 - Provided in the primary languages spoken by the population serviced by DH/CMC; translation services are utilized as needed
- If the balance is approved, the patient is sent a letter indicating approval.

E. Eligibility Criteria for Financial Assistance - HIV Patients. In order to qualify for financial assistance under this policy, a patient must meet the following criteria:

- Ryan White NH Cares HIV program for Part C and Part D. To qualify for the NH State (NH Cares funding), the patient must first apply for NH Medicaid and be denied. If denied, and income is below 500% of FPL, and if the patient is eligible and provides required documents, the grant will cover outpatient services for HIV care only. Inpatient services are not covered under this grant; however, these charges count toward the out-of-pocket charges. The grant provision requires a limit or cap of charges based on a percentage of patient income. Charges toward the cap include all medical care, home care, prescriptions, even if not provided by DH providers. The DH financial assistance is always applied before a cap on charges. Assets are not calculated for Part C and Part D cap on charges.

Requirements for the program:

- Diagnosis of HIV (Part C)
- Diagnosis of HIV or family member of woman/child with HIV

Requirements for the NH State HAB (NH CARES) program:

- Resident of NH
- Diagnosis of HIV
- Income at or below 300% FPL
- Must apply for Medicaid at least once a year

The chart below describes what percent of income a patient is expected to pay out-of-pocket before DH will stop charging the patient anything (co-pays, co-insurance, deductibles, or visit fees) for any further encounters.

Individual Income	Maximum Charge
-------------------	----------------

At or below 100% of current Federal Poverty Guideline	\$0
101% to 200% of current Federal Poverty Guideline	No more than 5% of gross annual income (example: \$18,000 income; \$500 cap on charges)
201% to 300% of current Federal Poverty Guideline	No more than 7% of gross annual income (example: \$33,000 income; \$2,310)
Over 300% of current Federal Poverty Guideline	No more than 10% of gross annual income (example: \$49,000 income; \$4,900)

- Income documents must be obtained from every patient under Part C or Part D grants at least once every year, and income verified every 6 months if DH FAA decision extends longer than 6 months. Supporting information includes one of the following:
 - Most recent tax return
 - Recent pay stub
 - Unemployment verification notice
 - Food stamps allocation
 - Social security income
- It is preferred the patient complete either the special HIV financial application, but the DH application will also be accepted. Additional information, such as housing accommodations must be obtained and tracked.

F. Assistance in Completing the Applications

You can receive in person assistance completing this application at the following locations:

Dartmouth-Hitchcock One Medical Center Drive Lebanon, NH 03756 (603) 650-8051	Dartmouth-Hitchcock Clinic Concord 253 Pleasant Street Concord, NH 03301 (603) 229-5080	Dartmouth-Hitchcock Clinic Manchester 100 Hitchcock Way Manchester, NH 03104 (603) 695-2692
Dartmouth-Hitchcock Nashua 2300 Southwood Drive Nashua, NH 03063 (603) 577-4055	Dartmouth-Hitchcock Keene 580-590 Court Street Keene, NH 03431 (603) 354-5454 ext:4444	Cheshire Medical Center 580 Court Street Keene, NH 03431 (603) 354-5430
Alice Peck Day Memorial Hospital 10 Alice Peck Day Drive Lebanon, NH 03766 (603) 443-9579	New London Hospital 273 County Road New London, NH 03257 (603) 526-5082	Visiting Nurse and Hospice for Vermont and New Hampshire (VNH) 88 Prospect St. White River Junction, VT 05001 (888) 330-8853
Mt Ascutney Hospital and Health Center 289 County Road Windsor, VT 05089 802-674-7471		

You will continue to be financially responsible for any services you receive until your completed application is received.

Additional options can be obtained through New Hampshire Health Access Network (<https://www.healthynh.com/nh-health-access-network.html>)

G. Financial Assistance Appeals Process

- If the balance is not approved, the patient will be sent a denial letter or if requested, a copy of the application highlighting the reason for disapproval. A letter outlining the formal appeals process is also sent with every denial or those letters providing only a partial reduction. The patient has 60 days to appeal this decision.
- A committee of three DH Leaders not involved in the original process will review the appeal and make recommendations on all denial appeals monthly.

H. Presumptive Eligibility for Financial Assistance

DH may utilize a third-party to review the patient's information to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socioeconomic and financial capacity score that includes estimates for income, resources, and liquidity. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for the Dartmouth Health system.

Information from the predictive model may be used by DH to grant presumptive eligibility in cases where there is an absence of information provided directly by the patient. Presumptive financial assistance is not available for balances after Medicare.

Presumptive screening is used, without respect to outstanding balance, on eligible accounts greater than 120 days after statements, after notices to collect the debt and prior to referral of the account to an outside collection agency to provide financial assistance to patients who have not been responsive to the notification of the option to complete a Financial Assistance Application. Probate accounts that have exceeded time limits are eligible for presumptive screening.

Presumptive Charity does not replace traditional FAP processes; it is used to supplement these efforts, and meant for those patients who are otherwise unresponsive to the tradition FAP process. To remove barriers for these patients, and improve our benefit to the patient, the hospital uses an electronic screening process prior to bad debt placement. Patients found eligible for presumptive charity will not be placed with a bad debt collection agency.

Inclusion in this program is based on a scoring algorithm using public record information and does not typically use a sliding fee scale. Partial discounts are not allowed with Presumptive Charity. Specific demographic populations are intended to include:

- Deceased with no estate or known family
- Transient, homeless person
- Persons estranged from family with no support group
- Patients unresponsive or incapable of completing the traditional process

Presumptive charity scoring incorporates a socio-economic factor and non-credit based data. The screening process leverages public databases that contain the following information:

- Consumer transactions
- Court records
- Asset ownership
- Home ownership vs. renter
- Demographics, economics of the region
- Employment status
- Utility files
- Governmental
- Files (Bankruptcy, SSN, deceased individuals)

Presumptive charity does not rely on credit bureau reporting data and leaves no soft hits on credit reporting. The information obtained incorporates a Presumptive Charity score of 0

(most needy) to 1000 (least needy). The information predicts the need of the guarantor based on the known factors including but not limited to Income, Assets and Liquidity.

Refunds:

If a patient has paid an outstanding balance and subsequently submits a completed Financial Assistance Application which is approved for financial assistance through the application process, the hospital will refund any amount the individual has paid for the care.

I. Charity Determination Levels

- Approval levels are as follows:

Position	Dartmouth-Hitchcock	Member Hospitals
Vice President/ CFO/President	>\$350,000	>\$100,000
Director Revenue Management	>\$50,000	>\$50,000
Director – Conifer	Up to \$50,000	Up to \$50,000
Manager – Conifer	Up to \$10,000	Up to \$10,000
Supervisor – Conifer	Up to \$1000	Up to \$1000
Account Rep – Conifer	Up to \$500	Up to \$500

J. Financial Assistance Exclusions – Services

a. Special Considerations

- The below medical procedures are not meant to be all inclusive.
- Non-medically necessary services, as deemed by the Provider could be excluded.
- All best efforts will be made to inform the patient prior to service of any new treatments not covered under the Financial Assistance Program.

b. Elective Cosmetic Procedures (not covered)

- Breast Capsulectomy w/implants
- Mastopexy (Breast lift)
- Gynecomastia (Male Breast Removal)
- Mastectomy (Cosmetic)
- Rhytidectomy (Face Lift)
- Blepharoplasty (Eyelids)
- Brow Lift (fat/wrinkles on forehead)
- Augmentation Mammoplasty (breast implants)
- Reduction mammoplasty (breast reduction if not covered by insurance)
- Rhinoplasty (nose)
- Dermatology Procedures
- Abdominoplasty (tummy tuck)
- Lipectomy of any kind (liposuction) – can also be listed as removal of excess skin or fat which is not deemed a medical necessity

Note: Above procedures are usually screened and identified by the Financial Information Coordinators. Exceptions to this policy, such as gender reassignment as deemed medically necessary, will be reviewed on a case-by-case basis.

c. Artificial Insemination

- Microreanastomosis (tubal reversal)
- Vasovasostomy (vasectomy reversal)
- Laparoscopy for treatment of infertility (IUI - IVF - GIFT Programs)
- Infertility treatment

d. Other

- Acupuncture
- Chiropractic Services
- Hearing aids and repairs
- Eye glasses
- Massage therapy
- Toric Lens
- Pharmaceuticals – prescription and over-the-counter medication
- Travel Clinic
- Blood Cord Study
- Retail Sales
- Services provided by Renaissance Psychiatry of New England, LLC

e. Financial Assistance ONLY after Medical Necessity has been approved

- a. Bariatric Surgery

f. Manchester and Nashua Divisions Only

- **Routine Eye Exams**
 - Only covered if determined to be medically necessary and/or there is an underlying medical condition.
 - In cases where these conditions do NOT exist, the scheduler will inform the patient that financial assistance will not apply.
 - Keene and Lebanon Ophthalmology write these off.

g. Exemptions

- Some services that fall under the elective and not medically necessary category, may be covered under the DH Financial Assistance Policy for all or some services related to the episode of care.
- Policies and procedures will be outlined for known services and maintained by the Patient Access Resource Team.
- These will be reviewed annually for needed revisions.
- Individual cases will be reviewed by Revenue Cycle leadership and the Vice President of Revenue Management for approval of the exception.

h. Financial Assistance Exclusions – Non DH Providers

Alice Peck Day Memorial Hospital

Amoskeag Anesthesia	Envision (ED and Hospitalist)	
---------------------	-------------------------------	--

Cheshire Medical Center

Radiology Associates of Keene	Surgicare – Medical Equipment	Monadnock Family Services
Amoskeag Anesthesia	Philip/Geneva	

Concord

Riverbend Community Mental Health	Services provided by Concord Hospital	
-----------------------------------	---------------------------------------	--

Manchester

Foundation Medical Partners		
-----------------------------	--	--

Nashua

Greater Nashua Mental Health Center (Social Worker)	Nashua Anesthesiologist Group	St. Joseph's Hospital (PT/Rehab Services)
---	-------------------------------	---

New London

Dr. Richard Rosato– Oral and Maxillofacial Surgery (professional)	Dr. Payal Verma - Oral and Maxillofacial Surgery (professional)	
---	---	--

Mary Hitchcock Memorial Hospital

Orthocare Medical Equipment	Philips/Geneva	
-----------------------------	----------------	--

Mt Ascutney Hospital

HCRS	Keene Medical	Dr. Knott, DMD
The Medical Store	MedStream Anesthesia	Orthocare
Peraza Dermatology Group	Tactile Medical	Willowbrook Prosthetics

VI. References N/A

Responsible Owner:	Finance Division Corporate	Contact(s):	Kimberly Mender
Approved By:	Chief Officer - Finance; Office of Policy Support - Organizational Policies Only; Cohen, Lisa; Fielding, Wendy; Muhlen, John; Roberts, Todd; Sanders, Tamara	Version #	15
Current Approval Date:	09/10/2025	Old Document ID:	RMD.0031
Date Policy to go into Effect:	09/10/2025		
Related Polices & Procedures:	<u>Uninsured Patient Discount Policy - Revenue Management Division</u> <u>Credit and Collection Policy</u> <u>Budget Payment Policy - Revenue Management Division</u>		
Related Job Aids:			