FORT BAYARD MEDICAL CENTER
FINANCIAL AND PAYMENT CONTRACT

Resident Name: _____ Social Security #: _____

Responsible Party: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Amount of resident's monthly income: _____

Monthly care and maintenance contract amount: $67.00

Check one of the following:

_____ Payment Plan: Self pay effective July 1st, 2012 at $320.25 per day/Low Level of Care or $502.17/High Level of Care.

_____ Payment Plan: Medicare Part A per diem until benefits have been exhausted or until skilled level of care has ended. _____ to cover daily SNF
(Name of insurance)
coinsurance from the 21st through the 100th day. Self pay or Medicaid after Medicare benefit period ends.

_____ Payment Plan: Medicaid at $320.25 LNF or $502.17 HNF per day. Medical necessity, Level of Care and length of stay will be determined in accordance with Medical Assistance Division, Medicaid Utilization Review (UR). Self pay if Medicaid not approved.

I hereby authorize Fort Bayard Medical Center to release medical and financial information as is necessary for processing my third party reimbursement claims to the parties identified, including, but not limited to, Social Security, Railroad, Medicare, Medicaid, and/or public or private insurers.

I, the undersigned, hereby agree to pay the charges for treatment at Fort Bayard Medical Center as per the above payment plan, submitted to Federal and State Law and Regulations. These charges will be based on established rates for treatment services and as reduced by the third party reimbursement, or provisions of Federal or State Law and Regulations. I understand Fort Bayard Medical Center does not have the authority to forgive debts owed to the State of New Mexico, and hereby authorize the acknowledgment of my account with Fort Bayard Medical Center or to their designated credit and collection representatives to allow for collection of delinquent accounts.

I, also agree that my financial commitment to Fort Bayard Medical Center will be maintained on a monthly basis, and I understand that failure to comply may result in the discharge of the above-mentioned resident, subject to and pursuant to all applicable Federal and State Laws and Regulations.

Resident / Responsible Party Signature: _____

Print Name and Relationship / Title: _____ Date: _____