Section 1: Please note, section 1 must be completed accurately and in its entirety. The Gibson Firm will be unable to begin work on accounts referred if any portion of this section is incomplete.

Nature of Issue: _____ Unpaid / Underpaid Claims

(check all that apply) _____ Refund Demand _____ Already Recouping

_____ Other, Describe: _____

_____

Unpaid Balance Sought: $_____

Refund Amount Requested: $_____ Amount Recouped $_____

STATE:_____

PROVIDER Name: _____

Facility Name: _____

Facility Address: _____(City)_____(St.)_____(Zip)_____

Fed Tax I.D.: _____ N.P.I.#: _____

Referring/Contact Person - Name, Tel. Number, and Email Address:

_____

_____

PATIENT Name: _____ **Account #:** _____

a) Address: _____(City)_____(St)_____(Zip)_____

b) Date of Birth: _____

c) Social Security #: _____

d) If the Patient Has Medicare, Entitlement Date: _____

Dates of Service:_____ **Charges: $**_____

(Attach Patient Demographics Page)

Section 2: Insurance - Please complete the following:

a) EMPLOYER: _____

i) Is this an EGHP? _____ Yes _____ No

ii) _____ Self Funded _____ Insured

b) Primary Insurance/Policyholder:_____

i) INSURER / TPA:_____

ii) Policy No.: _____

iii) SSN (If different than Patientôs):_____

iv) Deductible: _____ Co-Pay: _____

c) PPO Network: _____

i) In-Network: _____ Out of Network: _____

ii) If in Network, PPO Discount Percent: _____

iii) Is there any Letter of Agreement, Special Pricing Agreement or other Discount Payment arrangement with Insurer: _____ Yes _____ No

If so, summarize (and provide a copy): _____

_____

d) Has the Insurer, TPA, Employer, or EOB referenced other party(ies) used to determine benefit levels or refund amounts (i.e. Ethicare, AWAC, ELAP, Etc.); please detail: _____

_____

a) Secondary Insurance/Policyholder:

_____

i) Insurer / TPA:_____

ii) Policy No.: _____

iii) SSN (If different than Patientôs):_____

iv) Deductible: _____ Co-Pay: _____

<u>Section 3:</u> Documentation Check-List: Please provide all of the following documents applicable and available.

Note: *<u>Documents in **bold** must be provided before The Gibson Firm can begin work on the referred account</u>*.

✓ **ALL claims** (UB-92/04s) for DOS at-issue with <u>correct charges</u> for respective payer/s

- Are these Standard, Contract or Medicare Rates: _____
- Is Insurer entitled to a discount off amounts shown? _____

Provide "actual" amount insurer is responsible for paying on each claim, if it differs from totals shown on claims **(critical)**:

_____

✓ **Contracts** ○ **PPO** ○ **SPA** ○ **LOA** ○ Insurer (Please have available - send only if requested by TGF) ○ Other agreement: TPA, Etc.	✓ **<u>All</u>** correspondence (emails, letters, appeals, call notes, other) between billing group/facility and insurer, patient, employer, TPA, plan attorney, etc., including anything showing when facility was notified of denial or termination, if applicable
✓ **Insurance Card**	✓ **Medicare Card**
✓ Insurance Verifications	✓ All account notes
✓ **Assignment of Benefits**	✓ Any **refund demand** letters (if applicable)
✓ Medicare Secondary Payer Worksheet	✓ Patient Questionnaire
✓ **EOBs**, showing payments and / or offsets if applicable	✓ Financial logs or spreadsheets (or anything similar which depicts entire financial picture on referred account)

Section 4: Please include a **brief narrative** regarding this matter, including anything you believe we ñeed to knowà

Section 5: Provider-Attorney Per Case Agreement

_____ **(Provider) hereby engages The Gibson Firm LLC (TGF) to represent its interests in the above-described matter.** TGF will provide legal representation on a contingency fee basis in attempts to collect any unpaid, underpaid, or otherwise outstanding balances. When engaged to defend against refund demands or otherwise protect Providerôs assets already in its possession, TGF will provide legal representation for the fee of **$**_____ per hour.

For outstanding balance representation, Provider agrees that TGF shall be paid a percentage of the amount recovered as compensation for legal services rendered. Court costs and other necessary expenses must be paid by Provider, in addition to the contingent fee.

Provider will pay a contingency fee of _____**%** of any recovery made prior to commencement of litigation. Provider will pay a contingency fee of _____**%** for any recovery made after the commencement of litigation. Litigation includes proceedings in state or federal court, arbitration proceedings, participation in administrative agency hearings, or initiation of other formal adversarial proceedings. TGF will not commence litigation without the express written consent of Provider.

Date:_____ Authorized Provider Representative:

_____

Name:
Title:
Tel. No.: