



Smart Finance Options, Inc.

Medical Receivable Financing Application

Provider Legal Name: _____

DBA or Fictitious Names: _____

Provider Contact: _____

Type of Facility: Physician – Hospital – SNF – Long Term Care – DME – Other _____

License Number: _____ Tax ID Number: _____

Medicare Number: _____

Address: _____

County in which Facility is Located: _____

Telephone: _____ FAX: _____ E-Mail: _____

Administrator/Owner _____

Chief Financial Officer: _____

Manager of Collections: _____

Other: _____

What Liens exist against the accounts receivable if any?

Bank:	Yes	No	Amount _____
IRS:	Yes	No	Amount _____
Other:	Yes	No	Amount _____

Why does the Provider seek receivable funding? _____

How long does the Provider seek receivable funding? _____

How much cash is requested at initial funding? _____

Is there current or pending litigation against the Provider? _____

With Whom? _____

For What Amount? _____

Does Provider do its own payroll? _____ Third Party (Who)? _____

Are payroll taxes current? _____ If not, amount delinquent: \$ _____

Are Federal taxes current? _____ If not, amount delinquent: \$ _____

Are State taxes current? _____ If not, amount delinquent: \$ _____

Has Provider ever had a Medicare or Medicaid offset? _____ Amount of offset: \$ _____

Amount of previous offset(s) remaining unpaid: \$ _____

Is there a Medicare offset pending? _____ Estimated amount: \$ _____

Date of last Cost Report filing: _____

What is the average number of insurance claims billed per month?

Inpatient: _____ Outpatient: _____

What is the average dollar amount per claim billed?

Inpatient: _____ Outpatient: _____

Accounts Receivable Breakdown:

Insurance _____% HMO _____% Medicare _____% Self pay _____%

Medicaid _____% Workers Comp _____% Other (Specify) _____%

Please complete the following:

Payer Type:	Average Monthly Gross Charges	Net Collectible Percentage	Average Monthly Net Payment	Average Days To Pay
Commercial Insurance	\$	%	\$	
Medicare	\$	%	\$	
Medicaid	\$	%	\$	
HMO / PPO	\$	%	\$	
Workers Comp	\$	%	\$	

Total: \$ _____ Gross Billings \$ _____ Net Pay

What is the total amount of unpaid insurance claims aged less than 91 days in the above financial classes?

\$ _____

Please include the following items with your application:

- The last fiscal year's tax return & financial statements, and interim financial statements for current year.
- A list of principals of the organization.
- A current summary aged trial balance of your accounts receivable in 30 day increments grouped by payer type (i.e., Medicare/Medicaid, commercial insurance, etc.) as depicted in the form below:

Summary Aging: Days Outstanding					
Payer Type:	0-30 Days	31-60 Days	61-90 Days	91-120 Days	121+ Days
Commercial Insurance	\$	\$	\$	\$	\$
Medicare	\$	\$	\$	\$	\$
Medicaid	\$	\$	\$	\$	\$
HMO / PPO	\$	\$	\$	\$	\$
Workers Comp	\$	\$	\$	\$	\$
Blue Cross/ Blue Shield	\$	\$	\$	\$	\$
Self-Pay	\$	\$	\$	\$	\$
Other (Specify)	\$	\$	\$	\$	\$

Submitted By: _____ Date: _____

Reviewed By: _____ Date: _____

Once completed, please fax or e-mail this Application along with the Summary Aging to 888-547-7993 or E-mail to: info@smartfinanceoptions.com