



Healthcare Receivables Client Profile

Provider Information

Provider name _____
Present address _____
City _____ County _____ State _____ ZIP _____
Phone _____ Fax _____
Contact name _____ Title _____
Type of facility Physician Hospital SNF
 Long-term care Durable Medical Equipment Other _____
Structure Corporation Partnership Sole Proprietorship
License number _____ Federal Tax ID number _____
Administrator/Owner _____
Chief Financial Officer _____
Director of Patient Accounts/Business Office _____
Director of Data Processing _____
Manager of Collections _____

What liens exist against the accounts receivable?

Bank	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Amount _____
IRS	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Amount _____
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Amount _____

Why does Provider desire to sell receivables? _____
How long does Provider desire to continue selling receivables? _____
How much cash is requested at initial funding? _____

Is there current or pending litigation against the Provider?

Does Provider do its own payroll? _____ or use third party (name)? _____
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 offset? _____ Amount of offset _____
Amount of previous offset(s) remaining unpaid _____
Is there a Medicare offset pending? _____ Estimated amount _____
Date of last cost reporting filing _____

Please complete other side.

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

Inpatient _____ Outpatient _____

What is the average dollar amount of insurance claims billed per month?

Inpatient _____ Outpatient _____

What is the average total amount billed to insurance payors per month? (Complete below).

Payor type	Monthly Average Billed	Net Collectible Value	Average days to Pay
Commercial insurance	_____	_____ %	_____
Medicare	_____	_____ %	_____
Medicaid	_____	_____ %	_____
HMO/PPO	_____	_____ %	_____
Workers Comp	_____	_____ %	_____

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

Please attach a summary page from the aged trial balance.

FAX TO: 801-566-7458