

Crown Healthcare Negotiators

P.O. Box 151058 · Austin, Texas 78715

512-295-1414 · Fax 512-295-1515

chn-info@crownhealthcare.com

APPLICATION FOR ASSISTANCE

If you would like ***Crown Healthcare Negotiators*** to negotiate on your medical bills, the following information must be filled out in detail so that we may know the best avenue to take when negotiating on your behalf. Your application can either be faxed or mailed to ***CHN***.

Crown Healthcare Negotiators will generally respond via email, fax or by phone within 5 business days of receipt of your application. At that time you will be informed of the assistance that we will be able to provide.

DESCRIPTION OF SERVICES

Through ***Crown Healthcare Negotiators*** you can receive help with your medical bills, which are greater than \$1000 from a single provider.

We will do the following:

- 1.) Determine whether or not you are likely to qualify for government or private entitlement programs (Medicaid, etc.),
- 2.) Review the availability of third-party payers (insurance, etc.),
- 3.) Determine whether funds are available through charitable programs,
- 4.) Attempt to negotiate a settlement with the provider, and/or
- 5.) Attempt to arrange a payment schedule that you and the provider will accept.

GUARANTEE AND REFUNDS

We will refund to you any fee you paid for this service if we cannot arrange either a settlement that reflects at least a 20% reduction in the original principal of the bill(s) you submit, or a monthly repayment schedule in which the monthly payments are at least 20% less than your current repayment schedule. If you currently do not have a repayment schedule, we will guarantee to set one up for you.

STEP 1 of 3: Personal & Financial Information

Last / First Name _____

SS# _____ - _____ - _____ Gender _____ D.O.B. ____/____/____

Age _____ Marital Status _____ #Kids _____ Occupation _____

Guardian (if patient is a minor) _____

Home Phone _____ Wk Phone _____

Fax _____ Cell _____

Physical Address _____ Email _____

City Of Residence _____ County _____ St _____ Zip _____

The following questions are necessary because your providers will take these answers into account when considering what they are willing to do regarding your particular situation:

What was your adjusted gross income for last year? _____

How many dependants do you claim? _____

Do you have any source of insurance? _____ Name: _____

Do you own your own home? _____ Mortgage? _____ Est. Value: _____

Do you own any other property? _____ Est. Value: _____

Do you have savings? _____ \$ _____

Do you have any other resources? (CD's, Bonds, Stocks, etc.) _____ \$ _____

Do you have cash assets? _____ \$ value: _____

Have you ever applied for any type of financial assistance? _____ If so, explain:

STEP 2 of 3: **Medical Bill Information**

Provider Name	Date of Service	Account Number	Provider Phone Number	Bill Amount \$

Please note that there is an applicable fee for each provider listed.

STEP 3 of 3: Medical Information Release Form

Crown Healthcare Negotiators on behalf of:
P.O. Box 151058 · Austin, Texas 78715
512-295-1414, Fax 512-295-1515
Email: chn-info@crownhealthcare.com

MEDICAL INFORMATION RELEASE FORM

I hereby authorize any medical practitioner, hospital, medical facility, insurance company or any other agency that has medical records or knowledge of me or my dependents listed on this form, to release to CROWN HEALTHCARE NEGOTIATORS for the administration of my need. I authorize a copy of this form to be used in place of the original.

I hereby grant permission to CROWN HEALTHCARE NEGOTIATORS to discuss any and all of my medical bills with any medical provider. I understand that CROWN HEALTHCARE NEGOTIATORS will maintain the privacy of any information obtained and will not disclose that information to any other person or entity except by express written permission from me.

Signature of Patient (or legal guardian if a minor)

Print Name

Date

PATIENT INFORMATION

(Please Print Clearly)

Full Legal Name: _____

Social Security Number: _____ - _____ - _____ Gender: _____ D.O.B.: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____

Cell Ph: _____ Email: _____