Summit Physician Services
an affiliate of Summit Health

Dear Patient,

We recognize that these difficult economic times have caused many of our patients to find themselves without insurance. As a result, Summit Health has extended their Summit Care Discount Program to an increased number of families within Franklin County and the surrounding areas.

While Summit Physician Services and its providers recognize the need to offer care to our financially struggling patients, we also encourage our patients to take responsibility for their own healthcare.

Therefore, Summit Physician Services guidelines vary from the hospital Summit Care Discount Program. It's important that you are aware of these differences.

Most importantly, Summit Physician Services only offers discounts to patients who have applied for and been denied Pennsylvania Medical Assistance coverage. Patients must provide their Pennsylvania Medical Assistance denial to Summit Physician Services before discounts through the Summit Care Discount Program will be given. Without the denial, patients without insurance coverage shall be offered the Standard Prompt Pay Discount. Routine office visits and elective surgical procedures shall be rescheduled, until the Medical Assistance denial is received or payment is made by the patient. Patients with insurance shall be expected to pay their respective co-pays or co-insurance at time of service, until the Medical Assistance denial is provided to the office.

Patients with Medical Assistance shall not be eligible for additional discounts through the Summit Physician Services Summit Care Discount Program.

Patients will always be expected to pay a minimum fee for each service provided within the physician practice or by our physicians within the hospital. Please see the attached list of our most common services and application process.

Should you have any specific questions or needs or require additional information, please do not hesitate to speak directly with a member of our staff. If you have any questions, please contact Summit Physician Services – (717)-267-4839, ext.1975.

Sincerely,

L. Nicole Showe
Vice President, Physician Practices

Attachment

Summit Physician Services
Summit Care Discount Program Guidelines

Summit Physician Services Discount Program provides discounts ranging from 50% to almost 100% based on individual family financial needs. However, no service will be offered free of charge. The following minimum fees will apply for the listed provider services:

Office Visit	$20.00
Inpatient Visit per Provider	$20.00
Office Procedures	$50 - $100 based on complexity
Hospital or Surgery Center procedure	$250.00
Assistant Surgeon Fee	$100.00
Anesthesia Service	$250.00
OB Care	$500.00

The following are excluded from the Summit Physician Services Discount Program:

- Cosmetic Procedures
- Circumcisions
- Allergy tests, immunizations, injections, drugs
- Retail Services including, but not limited to:
- Hearing Aids, Cash Pay Physicals, Immigration Physicals, Travel Clinic
- Administrative Fees
- Billing Fee, Form Completion Fee, No Show Fee, Same Day Prescription Fee
- Any form of birth control including, but not limited to:
- Vasectomy, Tubal Ligation, IUD Insertion
- Childbirth Classes and Prenatal Visits

Discounts shall not be extended to accounts already in collection.

Discounts shall be extended to services occurring within 60 days prior to effective date. However, payments already paid by patients shall not be refunded as a result of Discount approval.

Discounts shall only be extended to patients living in our service area or to patients residing outside of our service area but their PCP is a Summit Physician Services provider.

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Financial Assistance Application for Summit Physician Services

Patient Name: _____ Date of Birth: _____
Home Address: _____
Phone Number: Home_____ Cell _____ Best Time to Call? _____

Household Members – (include only household dependents)

Name:		Relationship:	Date of Birth:	Social Security #:
1.	_____	Self	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Monthly Gross Household Income Received:

Wages/Salaries (before taxes): _____ Pensions/Annuities: _____
Social Security: _____ Other Disability: _____
SSI/SSDI: _____ Cash Assistance:_____
Unemployment Compensation: _____ Workers Comp Compensation: _____
Child Support: _____ Spousal Support: _____
Veteran's Administration (VA) benefits: _____ Interest/Dividends: _____
Other Income: _____

Household Resources:

Checking Account(s): _____ Savings Account(s): _____
Christmas/Vacation Club: _____ Stocks or Bonds: _____
Certificates of deposit: _____ Money market accounts: _____
Trust Funds: _____ US Savings Bonds: _____

For your application to be processed, the following information must be returned along with this form:

- Checking and Savings account statements showing detailed activity from the previous month (individual and business). Statements must show financial institution name and customer account name and number.
- Federal Tax Return including all schedules.
- Pay stubs or letter from employer listing wages before taxes for last 3 months
- Proof of all other monthly gross household income received during the year.

Have you applied for Medical Assistance in the past 90 days? Yes / No If Yes, please attach determination notice

Do we have your permission to share information contained in this application with other health care providers for them to determine financial assistance eligibility for their services? Yes / No

I certify that the information provided on this application is true and complete and may be checked for accuracy. I understand that willful falsification and/or omission of information contained in this application will result in denial of financial assistance.
Requestor's Signature: _____ Date: _____

If you have any questions, please call us for help: Summit Physician Services (717) 267-4839 ext. 1975. Please return the completed application to Summit Physician Services, Attn: Erica, 785 Fifth Avenue, Suite 3, Chambersburg, PA 17201.

_____ For Office Use Only_____
Approved Date: _____ Discount %: _____ Expiration Date: _____
Denied Date: _____ Reason for Denial: _____ Over Income _____ All documentation not received
Income: _____ Processor: _____ Date: _____