BeverlyHospital

Effective Date: 9/02
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Approved By:

PRESIDENT & CEO

POLICY/PROCEDURE MANUAL:	**[NUMBER: 01] ADMINISTRATIVE**
SECTION TITLE:	**Leadership [Section 0007]**
SUBJECT TITLE:	**Financial Assistance**
SUBJECT NUMBER:	**01.0007.015**
REFERENCE:	**California AB 774**

I. PURPOSE

Beverly Hospital is a non-profit organization, which provides Hospital services to the community of Montebello in Southern California. Beverly Hospital is committed to meeting the health care needs of all patients in the community, including those who may be uninsured or underinsured. As part of fulfilling this commitment, Beverly Hospital provides medically necessary services, without cost or at a reduced cost, to patients who qualify in accordance with the requirements of this "Financial Assistance" Policy.

The "Financial Assistance" Policy establishes the guidelines, policies and procedures for use by Hospital personnel in evaluating and determining patient qualification for Financial Assistance. This policy also specifies the appropriate methods for the Accounting and Reporting Financial Assistance provided to patients at Beverly Hospital.

II. POLICY

A. Financial Assistance Defined

1. Financial Assistance, often referred to as Charity Care, is defined as any necessary inpatient or outpatient Hospital service provided at Beverly Hospital to a patient who is unable to pay for care. Patients

unable to pay for their care must establish eligibility in accordance with requirements contained in the Beverly Hospital "Financial Assistance" Policy.

2. Depending upon individual patient eligibility, Financial Assistance may be granted on a full or partial aid basis. Financial Assistance may be denied when the patient or other responsible guarantor does not meet the Beverly Hospital "Financial Assistance" Policy requirements.

B. Financial Assistance Reporting

1. Beverly Hospital will report the amounts of Financial Assistance, full or partial, provided to patients as required for Charity Care. Charity Care reporting will be in accordance with the regulatory requirements issued by the Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition and any other subsequent clarification or advisement issued by Office of Statewide Health Planning and Development (OSHPD). To comply with these regulations, the Hospital will maintain this policy as written documentation regarding its Charity Care criteria. For individual patients, each Hospital will maintain written documentation regarding all Financial Assistance determinations. As required by Office of Statewide Health Planning and Development (OSHPD), Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

2. Charity Care will be reported as an element of the Hospital's annual Community Benefit Report submitted to Office of Statewide Health Planning and Development (OSHPD) and any other appropriate state agencies.

C. General Process and Responsibilities

1. Access to emergency medical care shall in no way be affected by whether Financial Assistance eligibility under this policy exists; emergency medical care will always be provided to the extent the facility can reasonably do so.

2. The Beverly Hospital "Financial Assistance" Policy relies upon the cooperation of individual applicants for accurate and timely submission of financial application information. To facilitate receipt of such information, Beverly Hospital will use a Financial Assistance Application to collect information from patients who:

   a. Are unable to demonstrate financial coverage by a Third Party Insurer and request Financial Assistance

   b. Are insured patients which indicate that they are unable to pay patient liabilities

   c. Any other patient who requests Financial Assistance

3. The Financial Assistance Application should be completed as soon as there is an indication the patient may be in need of Financial Assistance. The form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged. Accordingly, eligibility for the Beverly Hospital Financial Assistance Program may be determined at any time the Hospital has sufficient information to determine qualification.

4. Completion of a Financial Assistance Application provides

   a. Information necessary for the Hospital to determine if the patient has income and/or assets sufficient to pay for services

   b. Authorization for the Hospital to obtain a credit report for the patient or responsible party

   c. Documentation useful in determining eligibility for Financial Assistance

   d. An audit trail documenting the Hospital's commitment to providing Financial Assistance

D. Eligibility

1. Eligibility for Financial Assistance shall be determined solely by the patient's and/or patient guarantor's ability to pay. Eligibility for Financial Assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

2. The patient/guarantor bears the burden of establishing eligibility for qualification under any Financial Assistance Program. Patients/guarantors are required to provide timely, honest and complete disclosure in order to obtain Financial Assistance. The Hospital will provide guidance and/or direct assistance to patients or their guarantors as necessary to facilitate completion of government low-income program applications when the patient may be eligible. Assistance will also be provided for completion on an application for the Beverly Hospital Financial Assistance Program.

3. Completion of the Financial Assistance Application and submission of any or all required supplemental information might be required for establishing eligibility with the Financial Assistance Program.

4. Financial Assistance Program qualification is determined after the patient and/or patient guarantor establishes eligibility according to criteria contained in this policy. While Financial Assistance shall not be provided on a discriminatory or arbitrary basis, the Hospital retains full discretion to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for Financial Assistance.

5. Once determined, Financial Assistance Program eligibility will remain in effect for a period of 6 months and then may be renewed by the Hospital upon submission of required information by the patient. Patient Financial Services will develop methods for accurate tracking and verification of Financial Assistance Program eligibility.

6. Any eligible patient account balance created by a visit that resulted in the request for Financial Assistance Program coverage and those occurring for a period of 6 months following eligibility determination will be considered for write-off as Charity Care. Other pre-existing patient account balances outstanding at the time of eligibility determination by the Hospital may be included as eligible for write-off at the sole discretion of Hospital management.

7. Patient obligations for Medi-Cal Share of Cost (SOC) payments will not be waived under any circumstance. However, after collection of the patient share of cost portion, any other unpaid balance relating to a Medi-Cal Share of Cost (SOC) patient may be considered for Charity Care.

8. Factors considered when determining whether an individual is qualified for Financial Assistance pursuant to this policy may include, but shall not be limited to the following

    a. No insurance coverage under any government or other Third Party Program

    b. Household income

        NOTE: "Household" includes the patient, the patient's spouse, any individual to whom the patient is a dependent and any other individual legally responsible to provide for the patient's health care needs.

    c. Household net worth including all assets, both liquid and non-liquid

    d. Employment status

    e. Unusual expenses

    f. Family size as defined by Federal Poverty Level (FPL) Guidelines

    g. Credit history

9. Eligibility criteria are used in making each individual case determination for coverage under the Beverly Hospital Financial Assistance Program. Financial Assistance will be granted based upon each individual determination of financial need. To assure appropriate allocation of assistance, financial need may be determined based upon consideration of both income and available patient family assets.

10. Covered services include necessary inpatient and outpatient Hospital care providing the services are not covered or reimbursed by Medi-Cal/Medicaid or any other Third Party Payer. All patients not covered by Third Party Insurance and those insured patients who indicate that they are unable to pay patient obligations such as co-payments and deductibles, may be considered for eligibility under the Financial Assistance Program.

11. The Hospital will include a statement with each and every bill sent to a patient who has not provided proof of third-party coverage informing the patient that he or she may be eligible for medical coverage offered through the California Health Benefit Exchange, and other state- or county-funded health coverage, in addition to Medicare, Medi-Cal, Healthy Families and California Children's Services. This statement will also indicate how the patient may obtain applications for coverage offered through the California Health Benefit Exchange, and other state- county-funded health coverage programs, and that the Hospital will provide these applications.

    If a patient applies or has a pending application for another health coverage program at the time the patient applies for Financial Assistance at the Hospital, then neither application shall preclude eligibility for the program.

    The Hospital will provide each patient requesting Financial Assistance, or any patient the Hospital determines may be eligible for Financial Assistance, with a referral to a local consumer assistance center housed at legal services offices.

    The Hospital will provide the patient an application for the Medi-Cal program, the Healthy Families Program, or other state- or county-funded health coverage programs if the patient does not indicate coverage by a third-party payer or requests a discounted price or charity care. This application will be provided to the patient prior to discharge if the patient has been admitted to the Hospital, or for patients receiving emergency or outpatient care, the application will be provided to the patient when the patient is physically at the Hospital, unless the patient leaves the Hospital against medical advice, in which case the Hospital will provide the patient the application by mail at the address provided by the patient.

III. SCOPE

The "Financial Assistance" Policy will apply to all patients who receive services at Beverly Hospital. This policy provides guidance for all Hospital decisions to provide Financial Assistance, full or partial aid, to individual patients. All requests for Financial Assistance from patients, patient families, patient Financial Guarantors, Physicians, Hospital Staff, or others shall be addressed in accordance with this policy.

IV. INCOME QUALIFICATION LEVELS

A. Full Charity

1. If the patient's household income is 400% or less of the established poverty income level, based upon current Federal Poverty Level (FPL) Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the entire 100% patient liability portion of the bill for services will be written off as Charity Care.

B. Partial Charity

1. If the patient's household income is between 400% and 500% of the established poverty income level, based upon current Federal Poverty Level (FPL) Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the following will apply

a. Patient's care is not covered by a payer

1) If the services are not covered by any Third Party Payer so that the patient ordinarily would be responsible for the full billed, charges, the patient's payment obligation will be the gross amount the Medicare program would have paid for the service if the patient was a Medicare beneficiary.

b. Patient's care is covered by a payer

1) If the services are covered by a Third Party Payer so that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), the patient's payment obligation will be an amount that equals the difference between the amount paid by the Third Party Payer and the gross amount the Medicare Program would have paid for the service if the patient was a Medicare beneficiary. In the event the Third Party Payer has already paid an amount greater than the gross amount the Medicare Program would have paid for the service, no additional amount shall be due from the patient.

V. ASSET QUALIFICATION

A. Patient owned assets might be evaluated to determine if sufficient patient household resources exist to satisfy the Hospital's bill for services rendered. Evaluation of patient assets will consider both the asset value and amounts owed against the asset to determine if potential net worth is available to satisfy the patient payment obligation.

B. Recognizing the need to protect basic household assets, each patient family unit evaluated will be allowed the following asset exemptions

1. Primary residence

2. One (1) vehicle per patient or two (2) vehicles per family unit

3. $25,000 in other total assets

C. Patients who have assets beyond those specifically exempted will be expected to leverage the assets through independent financing in order to satisfy the patient account. Accordingly, patients with sufficient assets available are not qualified for the Beverly Hospital Financial Assistance Program. Patients with sufficient assets will be denied eligibility even when they meet basic income qualification requirements.

D. Notwithstanding the above, patients who qualify based on income level, but whose assets are marginally greater than the amounts specifically exempted, will be permitted to "spend-down" through liquidation of assets in order to meet Financial Assistance Program qualification levels. The specific amount of "spend-down" required will be determined on a case-by-case basis by Beverly Hospital management.

VI. SPECIAL CIRCUMSTANCES

A. Any evaluation for Financial Assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets net worth, income and expenses, prior to eligibility qualification for the Financial Assistance Program. Such Financial Assistance evaluations must be made prior to service completion by Beverly Hospital.

B. If the patient is determined to be homeless he/she will be deemed eligible for the Financial Assistance Program.

C. If the patient guarantor has recently been declared bankrupt by a Federal Bankruptcy Court, he/she will be deemed eligible for the Financial Assistance Program.

D. If the patient is deceased and there is no probate of the estate, or no estate exists, the patient will be deemed eligible for the Financial Assistance Program.

E. Patients seen in the Emergency Department, for whom the Hospital is unable to issue a billing statement, may have the account charges written off as Charity Care. All such circumstances shall be identified on the patient's Financial Assistance Application as an essential part of the documentation process.

VII. OTHER ELIGIBLE CIRCUMSTANCES

A. The Beverly Hospital deems those patients that are eligible for any or all government sponsored low-income assistance programs to be indigent. Therefore, such patients are automatically eligible and account balances are classified as Charity Care if the government program does not make payment for all services provided, or days during a Hospital stay.

B. For example, patients who qualify for Medi-Cal, California Children's Services (CCS), Child Health and Disability Prevention (CHDP), Healthy Families, Medical Services Initiative (MSI), County Medical Services Program (CMSP) or other similar low-income government programs are included as eligible for the Beverly Hospital Financial Assistance Program.

C. Any or all non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any other failure to pay for covered or non-covered services provided to Medical and/or other government low-income qualified patients are covered.

D. Patients with restricted coverage, and/or other forms of limitation shall have non-covered amounts classified as Charity Care when payment is not made by the low-income government program.

E. The portion of Medicare patient accounts for which the patient is financially responsible (coinsurance and deductible amounts), which is not covered by insurance or any other payer including Medi-Cal, and which is not reimbursed by Medicare as a bad debt, may be classified as Charity Care if:

1. The patient is a beneficiary under Medi-Cal or another program serving the health care needs of low-income patients;

2. The patient otherwise qualifies for Financial Assistance under this policy and then only to the extent of the write-off provided for under this policy;

3. Charity billing includes, but is not limited, to any unpaid co-insurance/deductibles, Medi-Cal denials and late charges for both traditional and HMO patients. These indigent patients are receiving a service for which a portion of the resulting bill is not being reimbursed.

F. Any insured patients who have Medi-Cal; traditional/HMO or any other indigent insurer as secondary or tertiary insurance will be automatically considered charity patients for remaining unpaid amounts including but not limited to any unpaid co-insurance/deductible, Medi-Cal denials and late charges.

G. Any patient who experiences a catastrophic medical event may be deemed eligible for Financial Assistance. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $75,000 may be considered for eligibility as a catastrophic medical event.

H. Any account returned to the Hospital from a collection agency that has determined the patient or guarantor does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or guarantor's inability to pay for services will be maintained in the Charity Care documentation file.

I. Public Notice

1. Beverly Hospital shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in high volume inpatient, outpatient and emergency service areas of the Hospital. Notices shall also be posted in the patient financial services and collection departments. Notices will include contact information on how a patient may obtain more information on Financial Assistance as well as where to apply for such assistance.

2. These notices shall be posted in English and Spanish and any other languages that are representative of 10% or more of the patients in the Hospital's service area.

3. Statements of accounts sent to patients as part of the routine billing process will contain information about the Beverly Hospital Financial Assistance Program.

J. Billing and Collection Practices

1. Patients in the process of qualifying for government or Hospital low-income Financial Assistance Programs will not be assigned to collections prior to 150 days from the date of initial billing.

2. Low-income patients, who at the sole discretion of the Hospital are reasonably cooperating to settle an outstanding Hospital bill, will not be sent to an outside collection agency if doing so would negatively impact the patient's credit.

3. Payment Arrangements – Patients will be asked to pay balance within a 90 day period. An extended payment plan will be made available (on a

case by case basis) and negotiated by the Patient Service Representative and the patient with the approval of the Patient Accounting Supervisor or Patient Accounting Manager to allow patient sufficient time to meet the terms agreed upon by both parties.

4. A reasonable payment plan will be offered to all patients meeting the eligibility requirements in situations where an agreement cannot be reached regarding a payment plan during the negotiation process between the Hospital and patient. This payment plan will require that monthly payments do not exceed ten (10) percent of a patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" are defined as expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses)including insurance, gas and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses.

   Any affiliate, subsidiary or external collection agency used by the Hospital to collect the patient's debt must first sign an agreement requiring the affiliate, subsidiary or external collection agency to comply with the Hospital's definition and application of a reasonable payment plan.

5. It is recognized that the need for Financial Assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive Financial Assistance. The orientation of Staff and selection of Personnel who will implement this policy shall be guided by these standards.

K. Good Faith Requirements

1. Beverly Hospital makes arrangements for Financial Assistance with Hospital care for qualified patients in good faith and relies on the fact that information presented by the patient is complete and accurate.

2. Provision of Financial Assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, inaccurate or incomplete information has been given. In addition, Beverly Hospital reserves the right to seek all remedies, including but not limited to civil and criminal damages from those who have provided false, inaccurate or incomplete information in order qualify for the Beverly Hospital Financial Assistance Program.

3. In the event that a patient qualifies for partial Financial Assistance under the Partial Charity component of this policy and then fails to make payment in full on their remaining patient liability balance, then the Hospital, at its sole and exclusive discretion, may use any or all-appropriate means to collect the outstanding balance.

VIII. REFERENCES

Charity Care: Policy and Procedures Accounting and Reporting Improvement Project by Clark, Koortbojian & Associates, Folsom, California AB 774, Chan. Hospitals: Fair Policies

Patient Accounting Policy and Procedure Manual, "Charity Allowance"

Finance Policy and Procedure Manual, "Charity of Indigent Care Data Accounting and Reporting Improvement"

IX. ATTACHMENT

Attachment A – Financial Assistance Application Form (English/Spanish)

Description of change	Reason for change	Approval by Signature	Approval date
Modified VI.A, VII.A, Added VII.E.3 and,F Changed Financial Assistance Form in English/Spanish into a single page form.	California Collection and Charity Care Eligibility Bill signed October 4, 2020.	Houshang Abd	1/12/2022

Approved By: Board of Directors, 9/24/02, 1/24/06, 12/12/06, 2/27/07, 4/26/11, 1/27/15, 1/23/18, 4/27/21, 2/22/22
Medical Executive Committee, 1/10/06, 2/12/07, 1/10/18, 4/14/21, 2/9/22
Clinical Support MSC, 11/17/05, 1/18/07, 1/3/18, 4/7/21, 2/2/22
Board Audit and Finance Committee, 9/17/02, 12/11/06, 2/20/07, 4/26/11
Administrative Committee, 9/13/02, 11/22/06, 3/2/11, 12/23/14
Document Control Committee, 12/22/14

ATTACHMENT A

FINANCIAL ASSISTANCE APPLICATION FORM

Provided in Accordance with Cal. Health & Safety Code §127425(e)(5)

Application Date:	Date of Service:	
Patient Name:	Account Number:	
Street Address:		Phone Number:
City, State, ZIP:		Patient Date of Birth:

Please **Call 323-725-4347** *for any questions about filling out this form.*

1) Was the patient a resident of California at the time of service? Yes No_
2) Did the patient have medical insurance at the time of service? Yes No_
3) Was the patient an active Medicaid recipient at the time of service? Yes No_

**If you answered *yes* to questions 2 or 3, please attach a copy of your insurance or Medicaid card to this application.

INCOME:

- **All adult family members' income must be disclosed.** Income includes gross (before taxes) wages, rental income, unemployment compensation, social security benefits, public assistance, dividends and interest, etc.
- "Family" is defined as follows: (i) for persons 18 years of age and older, family means spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (ii) for persons under 18 years of age, family means parents, caretakers, relatives, and other children under 21 years of age of the parent or caretaker relative. If the patient is a minor, the "family" is defined as the patient, the patient's natural or adoptive parents and the parent's other children (natural or adoptive) who live in the patient's home.

Family Member's Name	Age	Date of Birth	Relationship to Parent	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service

**Please attach additional family member information if applicable.

- **Proof of income must be supplied at the time of application (e.g., three months of pay stubs, most recent tax return (IRS Form 1040), etc.).**
- If you report $0 income, please provide a written statement of how you (or the patient) are surviving financially, including who provides food, shelter, transportation, etc. and how long you have been without income.

MONTHLY EXPENSES:		ASSETS This information may be used if your income is above 200% of Federal Poverty Level guidelines to determine whether you may be eligible for discounted care.	
Monthly rent/mortgage	**$**	**Checking account**	**$**
Utilities	**$**	**Savings account**	**$**
Car payment	**$**	**Business ownership**	**$**
Medical expenses	**$**	**Stocks and bonds**	**$**
Insurance premiums (life, home, car, medical)	**$**	**Real estate (excluding primary residence)**	**$**
Clothing, groceries, household goods	**$**		
Other debt/expenses (e.g., child support, loans, other)	**$**		

My signature below certifies that everything I have stated on this application is correct and subject to review under audit. I understand that if the information I provide is determined to be false, financial assistance may be denied and I may be responsible to pay for services provided.

Applicant's Signature Date

Please return completed application to:

Beverly Hospital
Attn: Patient Financial Services
309 W Beverly Blvd
Montebello, CA 90640

ATTACHMENT A

Proporcionado de acuerdo con Cal. Código de salud y seguridad §127425(e)(5)

Fecha de aplicación:	Fecha de Servicio:	
Nombre del Paciente:	Número de cuenta:	
Dirección:		Número de teléfono:
Ciudad, Estado, y código postal:		Fecha de nacimiento del paciente:

*Si tiene alguna pregunta sobre cómo completar este formulario por favor **llame al 323-725-4347**.*

1) El paciente era residente de California en el momento del servicio? Si No_
2) Tenía el paciente seguro médico al momento del servicio? Si No_
3) Tenía el paciente cobertura de Medical activa al momento del servicio? Si No_

**Si respondió si a las preguntas 2 o 3, adjunte una copia de su tarjeta de seguro o de Medical a esta solicitud.

INGRESO:

- Se deben divulgar los ingresos de todos los miembros adultos de la familia. Los ingresos incluyen salarios brutos (antes de impuestos), ingresos por alquileres, compensación por desempleo, beneficios de seguridad social, asistencia pública, dividendos e intereses, etc.
- "Familia" se define de la siguiente manera: (i) para personas de 18 años de edad o más, familia significa cónyuge, pareja de hecho e hijos dependientes menores de 21 años, ya sea que vivan en casa o no; y para las personas menores de 18 años, familia significa los padres, cuidadores, parientes y otros niños menores de 21 años del padre o pariente a cargo. Si el paciente es menor de edad, la "familia" se define como el paciente, los padres biológicos o adoptivos del paciente y los demás hijos de los padres (naturales o adoptivos) que viven en el hogar del paciente.

Nombre del miembro de la familia	Edad	Fecha de nacimiento	Relación con los padres	Fuente de ingresos o nombre del empleador	Ingresos de 3 meses antes de la fecha de servicio	Ingresos por 12 meses antes de la fecha de servicio

** Adjunte información adicional sobre miembros de la familia si corresponde.

- Se debe proporcionar comprobante de ingresos en el momento de la solicitud (p. Ej., Talones de pago de tres meses, declaración de impuestos más reciente (formulario 1040 del IRS), etc.).
- Si declara un ingreso de $ 0, proporcione una declaración por escrito de cómo usted (o el paciente) está sobreviviendo económicamente incluyendo quién proporciona comida, refugio, transporte, etc. y cuánto tiempo ha estado sin ingresos.

GASTOS MENSUALES:		**BIENES:** Esta información se puede utilizar si sus ingresos superan el 200% de las pautas del Nivel de pobreza federal para determinar si puede ser elegible	
Alquiler / hipoteca mensual	**$**	**Cuenta de cheques**	**$**
Utilidades	**$**	**Cuenta de ahorros**	**$**
Pago del coche	**$**	**Propiedad empresarial**	**$**
Gastos médicos	**$**	**Acciones y bonos**	**$**
Primas de seguros (vida, hogar, automóvil, médica)	**$**	**Bienes raíces (excluida la residencia principal)**	**$**
Ropa, comestibles, artículos para el hogar	**$**		
Otras deudas/gastos (por ejemplo, manutención infantil, préstamos, otros)	**$**		

Mi firma a continuación certifica que todo lo que he indicado en esta solicitud es correcto y está sujeto a revisión bajo auditoría. Entiendo que si se determina que la información que proporciono es falsa, se puede negar la asistencia financiera y puedo ser responsable de pagar los servicios prestados.

Firma del aplicante Fecha

Envíe la solicitud completa a:

Beverly Hospital
Attn: Patient Financial Services
309 W Beverly Blvd
Montebello, CA 90640