COMPANY NAME

Collection Attorney Form

Facility Name:

Patient Information:

Resident's Name:	Medical Record Number:
Date of Admission:	Payer:
Social Security #:	Current Status: Date:
Address Prior to Admission:	________ Still a Resident/Patient ___/___/______
	________ Discharge in Process ___/___/______
City, State, ZIP Code:	________ Discharged ___/___/______
Home Phone:	________ Expired ___/___/______

Responsible Party Information:

Name:	Social Security #:
Relationship:	
Address:	Home Phone:
	Work Phone: Ext.
City, State, ZIP Code:	

Account Information:

Total Amount Sent to The Lone Star Lawyer:	Dates of Service:
Amount of Last Payment:	Date of Last Payment:

Is any portion of the amount due for Medicare coinsurance? Yes______ No______ Amount: $_____________

Explanation of Account:

Attorney Documentation Required:

* Copy of Your Facility's Admissions Agreement with Resident and/or Legal Representative's signature.
* The Resident's Current or final Cost Ledger
* Individual Patient's collection record and correspondence documenting facility collection efforts.
* Itemized Statement (private statement, UB92, HCFA 1500, or appropriate state billing form) showing the amount billed to the Resident and/or Legal Representative
* Copies of previous collection letters sent to the Resident and/or Legal Representative
* Any other information that would be useful to the collection attorney.

Prepared by: Date Prepared:

APPROVALS:

Administrator's signature Date:

Business Office Manager's signature Date:

Please return this completed form to the Lone Star Lawyer, Howard M. Kahn, PO Box 3466, Houston, TX 77253 Phone 713-572-5246