Billing and Collection for Northern Light Health Hospital Services
(8/28/2026)

DEFINITIONS

Amount Generally Billed (AGB): The Amount Generally Billed for emergency or other Medically Necessary Care to individuals who have insurance covering such care. Northern Light Health calculates the AGB annually for each of its Member Organization hospitals. Northern Light Health may use either the look-back method or the prospective method to calculate to calculate AGB, as determined appropriate by each Member Organization Hospital.

- Under the look-back method, Northern Light Health calculates AGB by taking the total payments the applicable Member Organization hospital received from all commercial plans and Medicare during the Member Organization hospital's prior fiscal year and dividing the total by the gross hospital charges for services provided to beneficiaries under those commercial plans and Medicare during the same period.
- Under the prospective method, Northern Light Health determines AGB by estimating the amount that Medicare fee-for-service or Medicaid would allow for emergency or other medically necessary care, using the same coding and billing processes the hospital would apply if the patient were a Medicare or Medicaid beneficiary. The AGB amount under this method includes both the insurer's payment and the patient's cost-sharing obligations, such as deductibles, coinsurance, and copayments.

A free written description of how Northern Light Health calculates the AGB, as well as the applicable AGB for a particular Northern Light Health Member Organization hospital, is available upon request or by visiting http://northernlighthealth.org/billing-help

Application Period: The period during which a Northern Light Health Member Organization hospital must accept and process an application for financial assistance under the Financial Assistance Policy (FAP). The Application Period begins on the date the care is provided by the Northern Light Health Member Organization hospital to an individual and ends no earlier than the 240th day after the date the post-discharge billing statement for the care is provided or either:

- In the case of an individual who the Northern Light Health Member Organization hospital presumptively determined is eligible for less than the most generous assistance available as described in Section VIII(A)(1)(a), the end of the reasonable period of time for the individual to provide more information to obtain more generous assistance; or
- In the case of an individual, the Northern Light Health Member Organization hospital has notified of a planned ECA as described in Section VIII(A)(1)(b)(i) of this Policy, the deadline specified in the written notice to the individual.

Credit Balances: A negative amount on the accounts receivable that has the potential to be an overpayment (resulting in a refund or patient open balance transfer) or an over adjusted balance (resulting in a reversal of an adjustment code).

Emergency Care:

- An individual presents at the Emergency Department and a request is made for examination or treatment for any medical condition; or
- The patient is treated at a department or practice that is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for

emergency medical conditions on an urgent basis without requiring a previously scheduled appointment (e.g. an urgent care center, off-campus Labor and Delivery suite, etc.).

Extraordinary Collection Actions (ECAs): The following actions taken against an individual, or against any other individual who has accepted or is required to accept responsibility for the individual's Member Organization hospital bill for the care, related to obtaining payment of a bill for care covered under the FAP: (i) selling an individual's debt to another party; (ii) reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus; and (iii) actions that require a legal or judicial process (e.g. placing a lien on an individual's property, foreclosing on an individual's property, garnishing an individual's wages). ECAs **do not include** placing Member Organization hospital liens on a patient's property to obtain the proceeds of settlements, judgments, or compromises arising from a patient's suit against a third party who caused the patient's injuries.

ECAs also **do not include** a Member Organization hospital's sale of an individual's debt to another party if, prior to the sale, the Member Organization hospital enters into a legally binding written agreement with the purchaser of the debt containing four conditions:

1. the purchaser of the debt must agree not to engage in any ECAs to obtain payment of the debt;
2. the purchaser of the debt must agree not to charge interest on the debt in excess of the rate in effect under Section 6621(a)(2) at the time the debt is sold (or such other interest rate set by notice or other guidance published in the Internal Revenue Bulletin);
3. the debt must be returnable or recallable by the Member Organization hospital upon a determination by the Member Organization hospital or the purchaser that the individual is FAP-eligible; and
4. if the individual is determined to be FAP-eligible and the debt is not returned to or recalled by the Member Organization hospital, the purchaser must adhere to procedures specified in the agreement that ensure that the individual does not pay, and has no obligation to pay, the purchaser and the Member Organization hospital together more than the individual is personally responsible for paying as an FAP-eligible individual.

ECAs also **do not include** the filing of a claim in a bankruptcy proceeding.

FAP: Financial Assistance Policy (System Policy 16-002, Financial Assistance for Northern Light Health Hospital Services).

FAP-Eligible Individual: An individual eligible for financial assistance under the FAP (without regard to whether the individual has applied for assistance under the FAP).

Medically Necessary Care: Medical services or supplies which:

- are ordered by a physician or another provider within his or her scope of practice and appropriate and necessary for the symptoms, diagnosis, or treatment of the medical or mental health condition;
- are provided for the diagnosis or direct care and treatment of the medical or mental health condition;
- meet the standards of good medical practice within the medical and mental health community in the service area;
- are not primarily for the convenience of the patient or a provider; and

- are the most appropriate level or supply of service which can safely be provided or, when necessary, as determined by utilization process review.

Self Pay: A person who pays out of pocket for a health-related service to cover the medical or surgical procedure performed (i) in absence of insurance, (ii) as cost sharing under an insurance plan, (iii) or as directed by the person as their preference for payment rather than utilizing their insurance.

Workforce Member: Individuals providing services to or on behalf of the organization (such as employees, volunteers, Board members, medical staff members, students, trainees, and contractors).

PURPOSE

The intent of this Policy is to preserve assets and maintain a sound financial basis for operations while balancing the needs of our community and the patients that we serve.

POLICY

The Policy provides management with general guidelines for acquiring and verifying information and collecting payment from patients, their guarantors, third party insurance companies, and others financially responsible for payment of health care services. This Policy is also intended to promote Northern Light Health compliance with state and federal laws and regulations in performing all of these functions.

- Northern Light Health Member Organization hospitals do not exclude or discriminate on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic stats, genetic information, veteran status, sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender, gender identity or expression, or language in providing its services.
- Northern Light Health Member Organization hospitals will provide free care to uninsured and underinsured patients in accordance with applicable Maine Department of Health and Human Services regulations and System Policy 16-00, Northern Light Health's Financial Assistance for Northern Light Health Hospital Services.
- Northern Light Health Member Organization hospitals will assist uninsured patients in applying for health care coverage from federal, state, and/or publicly funded sources whenever appropriate.
- This Policy assumes that the outstanding balance pursued is owed by the patient/guarantor.
- Northern Light Health Member Organization hospitals will maintain proper controls and standardize manual adjustment practices when the balance has been deemed uncollectable according to the standards set forth by the System's Revenue Cycle department.
- Northern Light Health Member Organization hospitals will maintain proper controls and standardize manual Credit Balance processing practices according to the standards set forth by the System's Revenue Cycle department. The information contained and referenced in this Policy applies solely to Member Organization hospital-based services,

including Member Organization hospital employed practice groups, but does not extend to non-employed providers.

Northern Light Health Member Organization hospitals will make every reasonable effort to:

1. Obtain and verify insurance and demographic information necessary to determine the patient's or guarantor's responsibility for payment at the time of scheduling or registration.
2. Collect any applicable **point of service** patient responsibility.
3. Assist with **case management** during Member Organization hospital stays.
4. **Notify** patients of the availability of Financial Assistance consistent with System Policy 16-002, Financial Assistance for Northern Light Health Hospital Services.
5. Submit applicable claims to third party payers as authorized by patients.
6. Provide patients with a clear and accurate statement of amounts owed when applicable.
7. Communicate payment options and the availability of financial assistance programs including free care.

It is the patient's responsibility to provide the Member Organization hospital with the necessary financial and personal information that is required to determine eligibility for applicable third party coverage or financial assistance. All information gathered pursuant to this Policy will be treated confidentially in accordance with applicable federal and state privacy laws. The patient has the ultimate responsibility to understand their specific insurance benefits and requirements and to assure that proper prior authorization(s) and referral(s) have been obtained.

PROCEDURE

I. SCHEDULING & REGISTRATION

A. Whenever possible, patients will be pre-registered, during which time insurance and demographic information will be obtained. The Member Organization hospital will make reasonable efforts to verify patient information when services are scheduled or at the time the patient receives services. If more than one payer source exists, the Member Organization hospital will prioritize the payer sources based on Medicare Secondary Payer (MSP) rules and commercial insurance coordination of benefit guidelines.

B. All emergency services will be rendered in compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA). Following initial screening, evaluation, and stabilization, the Member Organization hospital will seek to obtain from the patient, guarantor or family member demographic and insurance information.

C. Patients may be requested to provide identification such as a driver's license to ensure accuracy of demographics and to provide proof of insurance coverage by presenting a valid insurance card.

D. To be considered "insured" the patient must sign a Consent to Treatment Guarantee of Payment Assignment of Benefits Protected Health Information form to assign benefits to the Member Organization hospital.

II. INSURANCE VERIFICATION

A. The Member Organization hospital will verify insurance for most major payers.

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B. The Member Organization hospital will verify that the patient's primary care provider has obtained, whenever possible, prior authorization for treatment. The Member Organization hospital utilizes tools such as payer web portals to help facilitate the identification, confirmation, and eligibility status of the information provided by the patient.
C. The Member Organization hospital reserves the right to contract with outside agencies to help obtain and verify billing information and assist patients in applying for federal and state assistance programs.
D. Automobile accident cases will be investigated, and details of the accident may be obtained from the Maine Bureau of Motor Vehicles website. Claims for payment will be submitted to the appropriate automobile or medical insurance carrier, as guided by the payer and if the patient is uninsured. As allowed by this Policy, liens will be filed to secure payment for services provided. The liens are not filed against an individual's personal assets.
E. In instances where the patient states workers' compensation is responsible for covering the service but where the name of the carrier is unknown, the Member Organization hospital will attempt to contact employers (when all appropriate releases have been signed) or the Workers' Compensation Board to request workers' compensation insurance information.

III. POINT OF SERVICE COLLECTION

A. Patients will be billed for any co-pay, coinsurance, deductibles or non-covered services at the time of service.
B. The Member Organization hospital may request payment arrangement or payment in full for certain elective diagnostic tests, treatments or procedures prior to scheduling when such services are considered non-urgent.
C. Patients will be offered a point of service discount if estimated out of pocket expense is paid in full at time of discharge (this includes insurance co-pay, coinsurance and/or deductible amounts).
D. Financial counseling is available as noted in Section VI in this Policy and System Policy 16-002, Financial Assistance for Northern Light Health Hospital Services.

IV. CASE MANAGEMENT, HOSPITLIZATION & DISCHARGE

A. The Member Organization hospital will work collaboratively with the patient's third party case management team who may perform concurrent clinical review. Patients will be notified of any changes in coverage due to medical necessity determinations that will result in non-covered services and related out of pocket expense.
B. All insurance should be verified, forms completed, and signatures obtained prior to discharge where possible.

V. PATIENT NOTICE OF AVAILABILITY OF ASSISTANCE

A. Signage and Individual Notices: Northern Light Health Member Organization hospitals will provide patients with notice of the availability of financial assistance and free care in

accordance with System Policy 16-002, Financial Assistance for Northern Light Health Hospital Services.

B. Additional notice steps are required prior to a Northern Light Health Member Organization hospital initiating ECAs, as described in Section VIII below.

VI. BILLING & COLLECTION

A. **General Provisions**

1. All patients will be charged the same amount for the same services rendered regardless of payer source. Charge estimates will be provided in advance of receiving services and fully itemized bills will be provided upon request at any time.
2. Conversations with patients and family members concerning their account(s) will be documented in the patient accounting system.
3. Financial Applications and Determination Letters are retained either in hard copy or electronic format in the patient accounting system.
4. The actions described in Section VI do not constitute ECAs and may be conducted at any time.

B. **Third Party Billing**

1. The third party payer will:
   a. Receive claims for benefits filed on the standard uniform billing forms (UB-04 and CMS 1500) as required by the payer.
   b. Receive claims reported using standard revenue codes and CPT/HCPCS codes and claims will be submitted electronically when possible.
   c. Receive claims generated as early as five days after discharge.

2. The Member Organization hospital will:
   a. Bill insurance carriers in order of priority based on industry standard coordination of benefit guidelines.
   b. Follow up with payers regarding outstanding account balances at intervals specified by Member Organization hospital departmental guidelines.
   c. Pursue payers until reasonable efforts have been exhausted.
   d. Provide patients with a notice of non-coverage in advance of service when required.
3. Patients will be:
   a. Billed for any co-pay, coinsurance, deductibles or non-covered services.
   b. Billed for balances for non-covered services in compliance with payer requirements.
   c. Responsible for unpaid balances billed to non-contracted insurance plans.

C. **Self-Pay Billing**

If at any time during the collection process the responsible party reasonably disputes the bill, collection activity will be suspended until the matter is resolved and the outcome communicated to the patient.

1. An initial statement will be generated as early as 5 days after discharge or 2 days following re-class to Self-Pay.

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2. A prompt pay discount will be noted on the initial patient statement and available up to 30 days from the statement date as described in the Northern Light Health System Discounts, linked above this Policy as a Related Document.
3. Additional discounts may be offered to Self-Pay patients as described in the Northern Light Health System Discounts, linked above this Policy as a Related Document.
4. Payment in full is due upon receipt of the initial statement. Payments can be mailed, made via phone, or paid on-line (Billing Help Website). Most major credit cards are accepted.
5. Subsequent statements will be generated at least every 30 days.
6. The statement or billing notices may be accompanied by telephone calls, collection letters, personal contact notices, and any other notification method that constitutes a genuine and reasonable effort to contact the party responsible for payment. These routine collection actions may vary depending upon the age of the account and the amount of the outstanding balance.
7. Northern Light Health Member Organization hospitals will not charge interest on unpaid balances.
8. See System Policy 16-002, Financial Assistance for Northern Light Health Hospital Services for additional details.

D. **Payment Plans**

The Member Organization hospital realizes that there may be instances where payment in full is not financially feasible and may necessitate an appropriate payment or budget plan. The items listed below provide additional guidelines and criteria for payment plans.

1. Patients or their responsible parties are expected to pay their full liability for services rendered upon receipt of their first bill or in accordance with a mutually agreed upon installment payment plan.
2. Financial Counselors will discuss payment plan options available with the patient.
3. Delinquent payment plan accounts will be referred to a collection agency subject to Section VIII.B of this Policy.

E. **Non-Insured and Under-Insured Patients Free Care & Financial Assistance**

Northern Light Health Member Organization hospitals provide free care in accordance with the Department of Health and Human Services' Free Care Guidelines (Chapter 150 10-144) and may provide additional free care based on Northern Light Health policy (System Policy 16-002, Financial Assistance for Northern Light Health Hospital Services).

F. **Catastrophic Coverage**

If a patient does not qualify for free care and their patient responsibility places an undue financial burden on the patient, the VP of Finance, or designee, may offer a discount beyond what is normally available through financial assistance or our standard Self-Pay discount.

VII. LIMITATION ON AMOUNTS BILLED

With respect to emergency or other Medically Necessary Care, it is the policy of Northern Light Health to limit the amount charged to an FAP-Eligible Individual to AGB. More information may be found in System Policy 16-002, Financial Assistance for Northern Light Health Hospital Services.

VIII. EXTRAORDINARY COLLECTION ACTIONS (ECAs)

A. General Requirements Prior to Initiating ECAs

Northern Light Health Member Organization hospitals may not initiate any ECA for at least 120 days from the date that the Northern Light Health Member Organization hospital provides the first post-discharge billing statement for the care and until the individual has been notified of the FAP. Additionally, before engaging in ECAs against an individual, Northern Light Health Member Organization hospitals must make reasonable efforts to determine whether an individual is eligible for financial assistance under the FAP in accordance with **Section 1** below. ECAs may not be engaged in if the patient has made a satisfactory payment arrangement with the Member Organization hospital. Finally, prior to commencing any ECA, the VP of Finance or designee must determine that the Member Organization hospital has made reasonable efforts to determine whether an individual is FAP-eligible and has otherwise complied with this Policy. No ECA may be commenced prior to such determination by the VP of Finance or designee.

1. **Reasonable Efforts**

   A Northern Light Health Member Organization hospital will be deemed to have made reasonable efforts to determine whether an individual is eligible for financial assistance under the FAP if the Northern Light Health Member Organization hospital either: (i) determines the individual meets the requirements for a presumptive eligibility determination; or (ii) within 15 days of receiving an application, notify the applicant to clearly explain what additional information or documentation, if any, is necessary to complete the application; or (iii) within 45 days of receiving a completed financial assistance application provides notice to the individual about the FAP and processes any FAP application submitted by the individual (whether the application is complete or incomplete) in accordance with the following procedures and System Policy 16-002, Financial Assistance for Northern Light Health Hospital Services.

   a. To make a presumptive eligibility determination, the Member Organization hospital must determine that the individual is eligible for financial assistance based on information other than that provided by the individual or based on a prior FAP-eligibility determination. If the individual is presumptively determined to be eligible for less than the most generous assistance available under the FAP, the Member Organization hospital must:

      i. Notify the individual of the basis for the determination and how to apply for more generous assistance under the FAP;

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ii. Give the individual a reasonable period of time to apply for more generous assistance before initiating an ECA; and
iii. If the individual submits a complete FAP application seeking more generous assistance within the Application Period, take the steps described in **Section 3** below.

b. In order to provide adequate notice to an individual about the FAP, Northern Light Health Member Organization hospitals must do all of the following:
   i. Notify the individual about the FAP in **all** of the following ways, at least 30 days prior to initiating one or more ECAs:
      1. Provide the individual with a written notice that indicates financial assistance is available for eligible individuals, identifies the ECAs that the Northern Light Health Member Organization hospital intends to use to obtain payment, and states a deadline after which ECAs may be initiated, which deadline is no earlier than 30 days after the date the written notice is provided.
      2. Enclose a plain language summary of the FAP with the written notice.
      3. Make a reasonable effort to orally notify the individual about the FAP and how the individual may obtain assistance with the FAP process.
   ii. If the individual submits an **incomplete** FAP application during the Application Period, the Northern Light Health Member Organization hospital will take the following additional steps outlined in **Section 2** below.
   iii. If the individual submits a **complete** FAP application during the Application Period, the Northern Light Health Member Organization hospital will take the following additional steps outlined in **Section 3** below.

2. **Additional Procedures if an Incomplete FAP Application is Submitted**
   a. In addition to complying with the notice requirements described in **Section 1** above, Northern Light Health Member Organization hospitals must, within 15 days of receiving an incomplete FAP application submitted during the Application period, provide the individual with notice of how to complete the FAP application and a reasonable opportunity to do so within 30 days.. In order to satisfy these requirements, Northern Light Health Member Organization hospitals must do all of the following:
      i. Not initiate, or take further action on previously initiated, ECAs.
      ii. Provide the individual with a written notice within 30 days that contains the following information:
         - Description of the information and/or documentation under the FAP or FAP application form that must be submitted to complete the FAP application.
         - Contact information, including telephone number and physical location, of: (i) the Member Organization hospital office or department that can provide information about the FAP; and (ii) either (a) the Member Organization hospital office or department that can provide assistance with the FAP application process, or (b) at least one nonprofit

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organization or government agency that the Member Organization hospital has identified as an available source of assistance with FAP applications.

b. If the individual subsequently submits a complete FAP application during the Application Period, Northern Light Health Member Organization hospitals must follow the procedures set forth in **Section 3** below.

3. **Additional Procedures if a Complete FAP Application is Submitted**
   a. In addition to complying with the notice requirements described in **Section 1** above, Northern Light Health Member Organization hospitals must, within 45 days of receipt, complete all of the following with respect to an individual who submits a complete FAP application during the Application Period:
      i. Not initiate, or take further action on previously initiated, ECAs.
      ii. Make a determination as to whether the individual is eligible for financial assistance under the FAP within 45 days. If the individual is determined to be eligible for financial assistance, the Northern Light Health Member Organization hospital must also take the steps listed in **Section 3.b.** below.
      iii. Notify the individual of the eligibility determination in writing, including the assistance for which the individual is eligible (if any) and the basis for the eligibility determination within 45 days.
   b. If the individual is determined to be eligible for financial assistance under the FAP, the Northern Light Health Member Organization hospital must take the following additional steps:
      i. Refund any amounts paid for the care that exceeds the amount the individual is determined to be responsible for paying for as a FAP-Eligible Individual, unless the amount of the refund would be less than $5.00. Refunds are **only** for payments for the episode(s) of care to which an individual's FAP application relates.
      ii. Take all reasonable measures to reverse any ECA taken against the individual to obtain payment for the care (e.g. vacate any judgment, discharge any lien or levy, and remove any adverse information from a credit report).
      iii. If the individual is eligible for financial assistance other than free care, provide the individual with a billing statement that indicates: (i) the amount the individual owes for the care as an FAP-Eligible Individual; (ii) how that amount was determined; and (iii) the AGB for the care.

B. **Referral of Debt to Collections Agencies**

In addition to complying with the general requirements for ECAs set forth in Section VIII.A. above, Northern Light Health Member Organization hospitals must comply with the following additional requirements when referring an account to a debt collections agency.

1. Northern Light Health Member Organization hospitals require debt collection agencies to provide written assurances that the agency is compliant with the Fair Debt

Collection Practices Act and the American Collections Association (ACA), Codes of Ethics and Professional Responsibility. Based on delinquency criteria noted above, accounts will be listed on a bad debt prelist report, reviewed, and approved by an authorized Member Organization hospital representative, prior to transfer to a collection agency.

C. **Reporting to Credit Reporting Agencies**

In addition to complying with the general requirements for ECAs set forth in Section VIII.A. above, Northern Light Health Member Organization hospitals must comply with the following additional requirements when making a report to any credit reporting agency (e.g. Transunion, Experian, Equifax).

1. Accounts referred to a collection agency may be listed with a national credit reporting agency if the responsible party fails to make payment in full or a satisfactory payment arrangement with the collection agency.

REFERENCES

DHHS Rule 10-144 CMR. Chapter 150, Free Care Guidelines
Section 1322 of the Patient Protection and Affordable Care Act
Section 501(c) of the Internal Revenue Code

ATTACHMENTS

Northern Light Health System Discounts, linked above this Policy as a Related Document

This document was approved by the committee(s) noted below on the date(s) as noted:

Board of Directors, 10/17/2012, 12/16/2015, 10/4/2017, 10/2/2019, 6/09/2021, 06/14/2023, 06/11/2025, 05/27/2026
Board Governance Committee, 9/19/2012, 2015 deferred, 9/12/2017, 9/18/2019, 05/09/2023
Board Finance Committee, 5/29/2012, 9/16/2015, 9/13/2017, 9/16/2019, 06/02/2021, 4/26/2023, 4/24/2025, 4/29/2026
Leadership Council, 6/19/2012, 11/17/2015, 05/19/2021
Finance Council, 9/8/2015, 8/8/2017, 4/19/2021, 1/27/2023, 3/25/2025, 4/24/2026

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