Patient Financial Services

EJ Noble Hospital offers a variety of services to all persons, insured or uninsured, to help you. Our well trained staff in the Billing Department is able to assist you with any and all questions regarding your insurance needs.

Our Patient Advocate is highly trained to assist in applying for Medicaid, Child Health Plus, Family Health Plus and any questions regarding your Medicare concerns.

Our Credit Office can handle your accounts to suit your financial needs (monthly payments, settlements, etc.) EJ Noble Hospital offers a Sliding Fee Discount to all self pay patients that meet certain income criteria. Our office also participates with the Charity Care Program. Call 287-1000 Ext. 213 or 535-9213 with any questions.

Together, EJ Noble Hospital of Gouverneur, is able to provide professional medical care as well as professional care for your financial needs. Should you have any further questions, please feel free to contact us at 287-1000.

IMPORTANT NUMBERS:
Billing Office: 287-1000 Exts. 201, 202, 203, 204, 206
Credit Office: 287-1000 Exts. 213, 212
Patient Advocate: 287-1000 Ext. 364

EJ Noble Hospital of Gouverneur adheres to any and all laws regarding patient confidentiality. All information obtained is strictly kept confidential.
EJ Noble Hospital

Application for Charity Care & Sliding Fee Scale

Patients Name: ________________________
Guarantor Name: ______________________
Address: ______________________________
Telephone No. (____) ____________ - ________

Employment:
Employer: ______________________________
Address: ______________________________
Telephone No. (____) ____________ - ________
Employment Status: FT  PT  Per Diem

Income:
Wages/Self Employment Current Mo. Last 12 Mo.
Public Assistance or SSI
Unemployment or Work Comp
Alimony or Child Support
Pensions
Income from Rent, Dividends
Interest and any other source

**Verification of all income sources must be submitted with this application. Acceptable verification includes a copy of your last three paystubs from employer or unemployment agency, statements from Public Assistance or Social Security, etc. If you do not have, or are unaware of what to send for verification, please call 287-1000 Ext. 213 and ask for our Financial Counselor for assistance.

Are you eligible for Medicaid? Y N (circle one)

Household size: ____________
Name: ________________________
SS# ________________________ DOB ________

Name: ________________________
SS# ________________________ DOB ________
Name: ________________________
SS# ________________________ DOB ________
Name: ________________________
SS# ________________________ DOB ________
Name: ________________________
SS# ________________________ DOB ________

* Social Security Numbers are not required, but helpful.
* Should the financial department require more information, an additional application will be sent to you for verification.

CERTIFICATION: In signing this application, I affirm that the information I have given, or have been requested to give as a basis for Charity Care/Sliding Scale Discount, is true and correct.

Signature __________________ Date ________

Financial Solutions

Phone: 287-1000 Ext. 212, 213
Fax: 535-9207

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