WELLSTAR CHANGE GUARANTOR REQUEST FORM

(PLEASE PRINT AND COMPLETE ALL APPLICABLE SECTIONS)

INSTRUCTIONS

- A separate request must be completed from each account/visit to a Wellstar Facility.
- Please complete all information requested below.
- Any missing or inaccurate information will cause a delay in fulfilling this request.
- Please attach a copy of any photo ID available for the current and requested guarantor.
- Both individuals must sign (on reverse side) in order for the guarantor change to be completed.
- If insurance information is needed, please attach a legible copy of both sides of the insurance card.
- If this form is not completed in person a notary public is required for signature verification.
- Return completed form to: WellStar Health System
  ATTN: Customer Service Department
  PO BOX 670747
  Marietta, GA 30066-0130
- If there are further questions, please call 770-792-5400
  (Your request will be processed as quickly as possible upon receipt of this completed form. Please allow at least 2 weeks from the mail date). Thank you!

PATIENT INFORMATION Account Number: __________________________ Facility: ___________________ Date of service: _______________

Last Name | First | Middle | DOB/Age | Race | Sex (M/F) | Social Security #

Home Address | City | State | Zip

NEW GUARANTOR INFORMATION Relation to Patient: ____

Last Name | First | Middle | DOB/Age | Race | Sex (M/F) | Social Security #

Home Address | City | State | Zip

County | Home Phone # | Marital Status | Emp Status | Work Phone#

Is it okay to leave a message at any of the above listed phone numbers? Y/N
If No, which phone numbers and list a number where a message may be left: ____

Are you (new guarantor) the Policy holder for insurance? If yes, please provide the information required, and submit a copy (Front and back) of the insurance card.

Name of Insurance _________________________________, please include all applicable information such as networks or repricing centers; for Blue Cross or Blue Choice please indicate the state where the policy is issued (example: Blue Cross/Blue shield of Alabama)

Policy/Subscriber number: ____Group number: ____________________________________

Patient's relationship to the policy holder: _____________________________ Insurance Company phone number: __________________________

Complete mailing address for the insurance company

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I am requesting a change of guarantor for the account listed on the first page of this document for the reason(s) listed below:

____

____

I understand that the change will only occur for the one account listed. I understand that I must submit a separate request for any other accounts that have a need for correction.

____

Witness **Date** **Signature of current guarantor**

Place Notary seal here Sworn to before me on this _____ day of the month _______ in the year ________

When applicable Notary Signature: ____

I. **FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:** I, the undersigned, hereby authorize payment directly to WellStar Health System and treating physicians of the insurance benefits otherwise payable or due to become payable. I understand and agree that I am financially responsible for any charges not covered by this assignment of insurance benefits. In addition, I hereby assign to the hospital my rights under Georgia Law to have any insurance claim processed and/or paid within 15 working days of the receipt of the claim by the insurance company. It is further agreed that any credit balance resulting from insurance payments or other sources that are refundable to the responsible party will be applied to any other account owed to WellStar Health System by my family or me. Additionally, if WellStar elects to pursue an appeal of any denial by my payor of the payment for services rendered, this constitutes written consent that WellStar and or its agents have the authority to pursue any and all appeals on my behalf.

II. **ASSIGNMENT OF MEDICARE AND MEDICAID BENEFITS, PATIENT CERTIFICATION AND PAYMENT REQUEST:** I hereby certify that the information given by me in applying for payment under title XVII and XIX of the Social Security Act is correct. I request that payment of the authorized benefits be made and assigned the benefits payable for services rendered during this admission to the physician or organization furnishing the services. The undersigned if other than the patient and the patient are responsible for and agree to pay charges not covered by this assignment, including any Medicare deductible.

III. **POTENTIAL LIABILITY:** The health insurance option you have selected may require prior authorization for coverage of each hospital inpatient admission and certification of hospital days beyond your established length of stay. If coverage for this service have been requested in this case and are not approved by your insurance company based upon medical information provided by the physician and/or WellStar Health System, you will be liable for total charges or a portion of the charges in accordance with your insurance program.

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SIGNATURE OF INDIVIDUAL ACCEPTING ACCOUNT GUARANTORSHIP **RELATION** **DATE**

____

Witness **Date** **Signature of current guarantor**

Place Notary seal here Sworn to before me on this _____ day of the month _______ in the year ________

When applicable Notary Signature: ____