NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Alister F. Martin MD, MPP
Health Commissioner

Dear Patient:

Thank you for choosing the New York City Health Department for your care. We are committed to making sure every New Yorker can access the services they need, regardless of their ability to pay.

We are required by Medicaid standards and other legal requirements to ask for health insurance information or a fee for clinic services provided to adults (age 19 and over).

- If you do not have health insurance or do not want your insurance billed for this visit, see **Section A.**
- If you want to use your health insurance to pay for the visit, see **Section B.**

If you do not have insurance or cannot pay the fee, you can still get services.

In New York City, access to health care is a right. All New Yorkers have health care access options, no matter your immigration status or income. If you do not have health insurance or have questions about your eligibility or need help with enrollment, our Enrollment Counselors can explain your options and help with enrollment or renewal. To speak with an Enrollment Counselor for free or one-on-one assistance about your options, call 347-665-0214. You can also submit a Health Insurance Inquiry Form response or find a counselor near you by visiting nyc.gov/healthcoverage – we offer help in many languages.

If you have questions about billing, visit nyc.gov/health and search for “clinic billing FAQ" or call 311 and ask about “health department clinic billing.”

We are grateful for the opportunity to serve you.

Sincerely,

Alister F. Martin MD, MPP
Health Commissioner

A. **If you do not have health insurance or do not want your insurance billed,** please use the sliding scale.

1. In the "Family Size" column, find the number of family members who live in your household, including yourself.
2. Read ACROSS and locate your yearly income. You will not be asked for proof of family size or yearly income.
3. Look DOWN at the bottom of that column to see how much you owe.
4. Complete a check or money order (not cash), payable to **NYC Department of Health and Mental Hygiene.**
5. Include **patient's name, date of visit and patient's ID number** (found on the label on the front of this letter) on the check or money order. The address to send payment is below.

Sliding Scale

Family Size	Yearly Income					
1	Under $31,300	$31,301 to $39,125	$39,126 to $46,950	$46,951 to $54,775	$54,776 to $62,600	Over $62,601
2	Under $42,300	$42,301 to $52,875	$52,876 to $63,450	$63,451 to $74,025	$74,026 to $84,600	Over $84,601
3	Under $53,300	$53,301 to $66,625	$66,626 to $79,950	$79,951 to $93,275	$93,276 to 106,600	Over $106,601
4	Under $64,300	$64,301 to $80,375	$80,376 to $96,450	$96,451 to $112,525	$112,526 to $128,600	Over $128,601
5	Under $75,300	$75,301 to $94,125	$94,126 to $112,950	$112,951 to $131,775	$131,776 to $150,600	Over $150,601
6	Under $86,300	$86,301 to $107,875	$107,876 to $129,450	$129,451 to $151,025	$151,026 to $172,600	Over $172,601
7	Under $97,300	$97,301 to $121,625	$121,626 to $145,950	$145,951 to $170,275	$170,276 to $194,600	Over $194,601
Fees	**$0**	**$20**	**$20**	**$30**	**$40**	**$50**

Fee Scale Examples:

- A single person (family size 1) with a yearly income between ($31,301 - $39,125) pays = $20.00
- A person living with 3 children, a spouse and a parent (family size of 6), with a yearly income between ($86,301- $107,875) pays $20.00

B. **Use your health insurance to pay for the visit**:

If you did not bring your insurance card today and wish to use your health plan to pay for services, please fill out the bottom of this page and send it to the mailing address below.

If you gave your insurance information at the clinic or are submitting it by mail, you are consenting to DOHMH to bill your health plan and receive payments on your behalf. Your health plan will mail you or the policy holder an Explanation of Benefits (EOB) to the address on file. The EOB will list unidentified service(s) code you received with the amount of copayment you may owe. If you owe a copayment, or you receive a check from your health plan for services you received, please mail a check or money order for the amount you received (not cash) payable to **NYC Department of Health and Mental Hygiene** to the address listed below. The check or money order should include the **patient's name, date of visit and patient's ID number** (found on the front of this letter).

Mailing address:

NYC Department of Health and Mental Hygiene
Attn: Division of Finance
42-09 28th Street, CN -48
Long Island City, NY 11101

Please bill the health insurance listed below for my visit: **EMR # _____**

Health Insurance Name: _____

Health Insurance Address: _____

Health Insurance Telephone Number: _____

Insurance ID: _____ Group Number: _____

If insurance coverage is through a spouse, parent or other:

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Insured: ( ) Spouse ( ) Parent ( ) Other

Signature: _____ **Date: _____**