Cape Regional Medical Center

Financial Assistance Policy ("FAP")

SUBJECT

Financial Assistance Procedures
Billing & Collection Procedures

PURPOSE

Cape Regional Medical Center ("Cape") is committed to providing the highest quality healthcare services to our community and strives to ensure that all patients receive essential emergency and other medically necessary healthcare services regardless of their ability to pay.

POLICY

It is the policy of Cape to ensure that all patients receive essential emergency and other medically necessary healthcare services. Financial assistance is available through a variety of programs for uninsured and underinsured individuals who do not have the ability to pay for all or part of the hospital services provided. Cape will ensure proper screening of uninsured and underinsured patients to determine eligibility for financial assistance available under this FAP.

Cape will provide, without discrimination, care for emergency medical conditions to individuals regardless of their financial assistance eligibility or ability to pay. It is the policy of Cape to comply with the standards of the Federal Emergency Medical Treatment and Active Labor Transport Act of 1986 ("EMTALA") and the EMTALA regulations in providing a medical screening examination and such further treatment as may be necessary to stabilize an emergency medical condition for any individual coming to the emergency department seeking treatment, regardless of the individual's medical or psychiatric condition, race, religion, age, gender, color, national origin, immigration status, sexual preference, handicap or ability to pay.

Financial assistance and discounts are only available for emergency or other medically necessary healthcare services. Not all services provided within Cape's hospital facility are covered under this FAP. Please refer to Appendix A for a list of providers that provide emergency or other medically necessary healthcare services within Cape's hospital facility. This appendix specifies which providers are covered under this FAP and which are not. The provider listing will be reviewed quarterly and updated; if necessary.

A Plain Language Summary of this FAP ("PLS") is also available. The PLS is a written statement that notifies an individual that the hospital facility offers financial assistance and provides additional information regarding this FAP in language that is clear, concise, and easy to understand.

FINANCIAL ASSISTANCE & ELIGIBILITY CRITERIA

Included below are the financial assistance programs offered under this FAP as well as the eligibility criteria that a patient must satisfy in order to qualify.

1. Governmental Programs:

a. **Social Security;**
b. **Supplemental Security Income - Medicaid (SSI); and**
c. **Presumptive Eligibility-Medicaid.**

2. State of New Jersey Programs:

a. <u>New Jersey Hospital Charity Care Payment Assistance Program ("Charity Care"):</u>

Charity Care is a New Jersey program in which free or discounted care is available to patients who receive inpatient and outpatient services at acute care hospitals throughout the State of New Jersey. Hospital assistance and reduced charge care are only available for necessary emergency or other medically necessary care.

Patients may be eligible for Charity Care if they are New Jersey residents who:

i. Have no health coverage or have coverage that pays only part of the hospital bill (uninsured or underinsured);

ii. Are ineligible for any private or governmental sponsored coverage (such as Medicaid); and

iii. Meet the following income and asset eligibility criteria described below.

Income Criteria: Patients with family gross income less than or equal to 200% of Federal Poverty Guidelines ("FPG") are eligible for 100% charity care coverage. Patients with family gross income greater than 200% and less than or equal to 300% of FPG are eligible for discounted care. Free care or partially covered charges will be determined by use of the New Jersey Department of Health Fee Schedule.

Income as a Percentage of HHS Poverty Income Guidelines	**Percentage of Medicaid Rate Paid by Patient**
Less than or equal to 200%	0% of Medicaid Rate
Greater than 200% but less than or equal to 225%	20% of Medicaid Rate
Greater than 225% but less than or equal to 250%	40% of Medicaid Rate
Greater than 250% but less than or equal to 275%	60% of Medicaid Rate
Greater than 275% but less than or equal to 300%	80% of Medicaid Rate
Greater than 300%	Uninsured Discount Rate Available

If patients on the 20% to 80% sliding fee scale are responsible for qualified out-of-pocket paid medical expenses in excess of 30% of their gross annual income (i.e. bills unpaid by other parties), then the amount in excess of 30% is considered hospital care payment assistance.

Asset Criteria: Charity Care includes asset eligibility thresholds which states that individual assets cannot exceed $7,500 and family assets cannot exceed $15,000 as of the date of service.

Charity Care may be available to non-New Jersey residents, requiring immediate medical attention for an emergency medical condition.

Charity Care eligibility guidelines are set by the State of New Jersey and additional information can be found at the following website: http://www.state.nj.us/health/charitycare/documents/charitycare_factsheet_en.pdf.

b. New Jersey Uninsured Discount (Public Law 2008, C. 60):

Uninsured patients with family gross income less than 500% of FPG may be eligible for discounted care under this program. Eligible individuals must be New Jersey residents.

If a patient has family gross income:

- Below $75,000, charges may be discounted to current Medicare rates.
- Between $75,001 and $100,000, charges may be discounted to current Medicare rates plus 5%.
- Between $100,001 and 500% of FPG, charges may be discounted to current Medicare rates plus 15%.

c. NJ FamilyCare:

NJ FamilyCare is New Jersey's publicly funded health insurance program which includes CHIP, Medicaid and Medicaid expansion populations. NJ FamilyCare is a federal and state funded health insurance program created to help qualified New Jersey residents of any age access to affordable health insurance. NJ FamilyCare is for people who do not have employer insurance.

Financial eligibility for individuals seeking eligibility for NJ FamilyCare will be based on their Modified Adjusted Gross Income or MAGI. NJFamilyCare eligibility guidelines are established by the State of New Jersey and can be found at www.NJFamilyCare.org. A patient can be presumed eligible for NJFamilyCare once in a twelve month period.

d. New Jersey Cancer Education and Early Detection ("NJCEED"):

The NJCEED program provides comprehensive outreach, education and screening services for breast, cervical, colorectal and prostate cancers.

A patient must be uninsured or underinsured and must have family gross income at or below 250% of FPG to be eligible. Additional information can be found at the following website www.nj.gov/health/cancer/njceed.

e. Catastrophic Illness in Children Relief Fund:

The Catastrophic Illness in Children Relief Fund provides financial assistance to families of children with a catastrophic illness.

In order to be eligible hospital expenses must exceed 10% of the family's gross income, plus 15% of any excess income over $100,000, the child must have been 21 years or

younger when the medical expenses were incurred and the family must have lived in New Jersey for 3 months immediately prior to the date of application. Additional information can be found at the following website: www.state.nj.us/humanservices/cicrf/home.

f. New Jersey Victims of Crime Compensation Office:

The State of New Jersey has established the New Jersey Victims of Crime Compensation Office to compensate victims of crime for losses and expenses, including certain medical expenses, resulting from certain criminal acts.

In order to be eligible for New Jersey Victims of Crime Compensation Office the crime must have occurred in New Jersey or must relate to a New Jersey resident victimized outside of the State, the victim must have reported the crime to police within 9 months and victim must cooperate with the investigation and prosecution of the crime. The claim must be filed within 3 years of the date of the crime and the patient must be an innocent victim of the crime. Additional information can be found at www.nj.gov/oag/njvictims/index.html.

g. Amounts Generally Billed ("AGB"):

Pursuant to Internal Revenue Code Section 501(r)(5), in the case of emergency or other medically necessary care, FAP-eligible patients will not be charged more than an individual who has insurance covering such care.

Patients may be eligible for this discount if they are uninsured and have family gross income less than 500% of FPG. Additionally, underinsured patients may be eligible if their family gross income is greater than 200% but less than or equal to 300% of FPG.

PROCEDURES/REQUIREMENTS

All patients who cannot afford to pay for services and/or have no health insurance to cover their services may apply for financial assistance at Cape.

- Patients arriving for non-emergent outpatient services with no insurance will be directed to Financial Counseling for screening.

- Emergency patients will be interviewed by a Financial Counselor after being examined by a physician when a counselor is available. If a counselor is unavailable the patient will be sent a letter the next business day notifying them of the availability of financial assistance under this FAP.

- Uninsured patients being scheduled for services will be referred to the Financial Counseling department for screening prior to being scheduled for the procedure.

- All inpatients are pre-authorized prior to coming in for services.

Patients will be interviewed and screened for free and/or discounted care in the following order:

- Governmental Programs (Social Security, Supplemental Security Income - Medicaid, Presumptive Eligibility - Medicaid);

- NJ FamilyCare, NJCEED, Catastrophic Illness in Children Relief Fund, New Jersey Victims of Crime Compensation Office;
- Charity Care;
- New Jersey Uninsured Discount; and
- AGB.

Governmental Programs

All patients will be screened by a Cape financial counselor to determine if they qualify for insurance prior to the determination of other financial assistance. Below summarizes the different programs that individuals will be screened for:

Medicaid: Cape financial counselors will assist patients who meet the eligibility criteria, with the application process. There are several types of Medicaid available through the New Jersey Department of Health. The financial counselors will help determine the program best suited for the patient's circumstances.

- **SSI - Medicaid:** Supplements Medicaid benefits with a monthly income stipend that can help with basic needs.

- **Presumptive Eligibility - Medicaid ("PE"):** Temporary one time per year coverage for persons who meet some basic eligibility criteria so that their healthcare costs can be covered while the NJ FamilyCare is being determined by the State of New Jersey. Cape's financial counselors will assist in completing the application

NJFamilyCare

If it is determined that a patient is eligible for NJFamilyCare and has not been presumed eligible in the last 12 months the Financial Counselor will complete an on-line application with the patient and submit it to the PE Unit for temporary Medicaid.

If a patient is eligible for NJFamilyCare and has been presumed eligible in the last twelve months they cannot be presumed eligible again. A referral will be made to the Cape May County Board of Social Services. A Charity Care Application will be started for the one visit and will be completed as a patient noncompliant with Medicaid if they do not complete the application for NJFamilyCare with County.

A PE application must be completed on the date of service.

Charity Care

The Charity Care program is a need based program. To apply, a patient must have an outstanding bill that is not covered by insurance or a prescription from a doctor for medically necessary services at Cape. Patients who believe they satisfy the eligibility criteria must submit a completed application with the following required documentation.

- ID for everyone in the household (Patient, spouse and dependent children);
- Proof of income for the household from ALL sources for the 30 days prior;
- Proof of New Jersey residency; and
- Proof of assets showing current balance as well as transactions for the 15 day period prior to the application date.

Please refer to the Cape Uncompensated Care or Reduced Charge Care Application which further outlines the documents required for submission with the Application. Additional documents may be required depending on the individual applicant's circumstance.

If a patient is admitted through the ER the state allows Cape to presume them eligible for Charity Care on a one-time basis. Patient is interviewed at time of service and release of information signed. If patient does not complete the application within a reasonable time (approximately 60-90 days) after discharge the Financial Counselor will use the release to attempt to verify patient's eligibility. A field representative will also attempt to locate patient to verify eligibility.

Non-New Jersey residents may apply for Charity Care for emergency services on a one-time basis. Nonresidents are not eligible for the one-time presumed eligible application. They must provide all required documents.

For patients who qualify at a percentage of Charity Care based on the New Jersey sliding scale included in Section 2(a) of this FAP; charges will be reduced to the current Medicaid rate. Patients will then be responsible for the remaining balance or the AGB amount; whichever is less.

If a Charity Care patient presents for a non-medically necessary service (i.e. court ordered drug test) patient will be charged the Medicare rate.

Patients have 365 days from the date of the first post-discharge billing statement to submit a completed application for Charity Care assistance. Cape may, at its discretion, accept applications after 365 days.

New Jersey Uninsured Discount

All uninsured individuals will be required to complete an "Application for Discount" and provide the necessary required information in order for Cape to make a determination with respect to eligibility for the New Jersey Uninsured Discount. All registration information will be reviewed such as employment status and occupation as well as possibility of insurance involvement. Please note that the Application for Discount outlines the documentation that is required to constitute a complete submission and allow Cape to make a fair eligibility determination.

Motor Vehicle Accident, Workers' Compensation or patients that have insurance but did not bring information with them will not have a discount applied.

Under this program an eligible patient will be charged an amount no greater than 115% of the applicable payment rate under the Federal Medicare program for the healthcare services rendered or AGB; whichever is less.

AGB

Patients that submit either a Cape Uncompensated Care or Reduced Charge Care Application or an Application for Discount ("Application") must submit the Application to qualify for AGB discounts offered under Internal Revenue Code §501(r)(5).

Patients will have a minimum of 365 days from the date of the first post-discharge billing statement to submit a completed application for discounts offered under Internal Revenue Code Section 501(r).

METHOD FOR APPLYING

Patients who meet the eligibility criteria and wish to apply for the discounts offered under this FAP can obtain Applications at http://caperegional.com/media/CRHSFinancialAssistanceApplication.pdf

Applications may be requested by calling the Cape Financial Counseling Office at (609) 463-2443. Paper copies of the Applications are also available at the Cape Financial Counseling Office located at:

Cape Regional Medical Center
South Lobby
2 Stone Harbor Boulevard
Cape May Court House, NJ 08210

The hours of operation are Monday – Friday 8am to 4pm.

Completed Applications (with required documentation) should be mailed to:

Cape Regional Medical Center
Attention: Financial Counseling
2 Stone Harbor Boulevard
Cape May Court House, NJ 08210

Process for Incomplete Applications

Financial assistance determinations shall be made as soon as possible, but no later than ten (10) working days from the date of the request. If sufficient paperwork is not provided, the request will be deemed to be an incomplete application.

If an incomplete application is received, Cape will provide the patient with written notice which describes the additional information/documentation needed to make a FAP-eligibility determination and give the patient a reasonable amount of time (30 days) to provide the requested documentation. Additionally, Cape, and any third parties acting on Cape's behalf, will suspend any extraordinary collection actions ("ECAs") (discussed later in this FAP) to obtain payment for a reasonable amount of time.

Process for Completed Applications

Once a completed Application is received, Cape will:

1. Suspend any ECAs against the individual (any third parties acting on Cape's behalf will also suspend ECAs undertaken);
2. Make and document a FAP-eligibility determination in a timely manner; and
3. Notify the responsible party or individual in writing of the determination and basis for determination.

If a patient is deemed FAP-eligible Cape will:

1. Provide a billing statement indicating the amount the FAP-eligible individual owes, how that amount was determined and how information pertaining to AGB may be obtained;
2. Refund any excess payments made by the individual; and
3. Work with third parties acting on Cape's behalf to take all reasonable available measures to reverse any ECAs taken against the patient to collect the debt.

Basis for Calculating Amounts Charged to Patients

Patients who qualify for charity care and have family gross income less than 200% of FPG will be eligible for a discount which covers 100% of charges.

Patients who qualify for charity care and have family gross income greater than 200% and less than or equal to 300% of FPG will be eligible for discounted care determined by the New Jersey Department of Health Fee Schedule.

Patients who qualify for the New Jersey Uninsured Discount will be charged an amount no greater than 115% of the applicable payment rater under the Federal Medicare program.

Cape has chosen to use the Look-Back Method to calculate its AGB percentage of 22%. The AGB percentage is calculated annually and is based on all claims allowed by Medicare Fee-for-Service + all Private Health Insures over a 12-month period, divided by the gross charges associated with these claims.

Any individual determined to be FAP-eligible will not be charged more than AGB for emergency or other medically necessary healthcare services pursuant to Internal Revenue Code §501(r)(5). The applicable AGB % will be applied to gross charge to determine the AGB.

Any FAP-eligible individual will always be charged the lesser of AGB or any discount available under this FAP.

WIDELY PUBLICIZING THE FAP, APPLICATIONS & PLS

Cape's FAP, Applications and PLS are available in English and in the primary language of populations with limited proficiency in English ("LEP") that constitute the lesser of 1,000 individuals or 5% of the community served by Cape's primary service area. Cape provides language interpreting and translation services, and provides information to patients with vision, speech, hearing or cognitive impairments in a manner that meets the patient's needs.

For the benefit of our patients, Cape's FAP, Applications PLS are all available on-line at the following website: http://caperegional.com/contact-financial-assistance.htm

Paper copies of the FAP, Applications and the PLS are available upon request without charge by mail and are available in at various areas throughout the hospital facility which include the emergency department, admissions/registration departments and patient financial services offices.

All patients will be offered a copy of the PLS as part of the intake/discharge process.

Signs or displays will be conspicuously posted in public hospital locations including the emergency department, admissions/registration departments and patient financial services offices that notify and inform patients about the availability of financial assistance.

Cape will also make reasonable efforts to inform members of the community about the availability of financial assistance. Cape accomplishes this through its involvement with various other agencies in Cape May County.

BILLING & COLLECTIONS

Procedures

Cape will use a full pre-admission policy and all the following requirements will be met prior to the Admissions Department assigning a room to a patient. No elective patient will be admitted without approval of the insurance company when appropriate or the Financial Counselor when there is no insurance involved.

Cape will not engage in any actions that discourage individuals from seeking emergency medical care, such as by demanding the emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities in the emergency department or other areas where such activities could interfere with the provision of emergency care on a non-discriminatory basis.

1. Inpatients - Insured Patients:

    a. All elective patients are required to complete a pre-admission form prior to admission. These patients must be referred by a physician's office.
    b. The pre-admission form will go to the appropriate intake representative in the Patient Access area for insurance verification along with referrals when applicable.
    c. All the above information will be reviewed by the patient account representative on the back end for authorization from insurance company when appropriate.
    d. An Assignment of Benefits form will be signed. All patients, whether insured or not, are required to present documentation of proper identification.

2. Inpatients – Uninsured Patients:

    a. A pre-admission form and an interview with the Financial Counselor to arrange payment arrangements prior to admission.
    b. A deposit will be required and reasonable payment plan negotiated, based on the patient's ability to pay and the types of services to be provided, patient signature will be required on all paperwork.
    c. A charity care application will be taken when applicable.
    d. If patient is not eligible for charity care the patient will be offered the New Jersey Uninsured Discount depending which tier the patient is eligible to receive.

3. Inpatient – Emergency Admission:

    a. The Admissions Department, Credit Department and Patient Account Representative will work together to complete all the required information.
    b. A daily report is run regarding all uninsured patients. These patients are seen by the financial counselors before discharge when possible to collect co-pays, deductibles or to assist in making payment arrangements or applying for financial assistance.

4. Outpatient – Ancillary Patients:

    a. All patients must be registered prior to receiving outpatient services.
    b. Documentation of proper identification and health insurance coverage with referrals or authorizations, if applicable, must be present at time of registration for outpatient services.

c. If a patient presents for services with no insurance they must first visit the financial counselor's office to make payment arrangements and apply for financial assistance. There is a discount given for payment in full at time of service.

5. Outpatient – Emergency Room:

    a. Identification is required, if the patient has no ID, the registration clerk will assist in proving the patient's identify through a phone call when applicable.
    b. Appropriate insurance cards or proper identification will be required.
    c. Credit arrangements will include signing a financial responsibility form.
    d. A letter is sent by the credit department the next day after services asking the patient for insurance information, informing them of payment arrangements available, and informing them of the charity care program. Phone numbers are given for the patient to contact the office with the information.

Billing Procedures

It is the policy of Cape to bill all insurances as a courtesy to our customers. Cape will ask for copays and deductibles when the customer presents for services in our Emergency Room or Patient Access area.

1. Insurances:

    a. Working with the Patient Access Department Cape will work all accounts that do not present with insurance information by checking web site, passport and any other means at our disposable to get the correct insurance information.

2. In-Network Insurances:

    a. Cape will pro-rate the system according to the contract that is in place at the time of service. All co-pays and deductibles that are applied by the insurance will be dropped to the patient's responsibility.

3. Out of Network Insurances:

    a. Cape will do everything possible to assist the patient in getting final resolution by explaining the appeals process with their insurance and providing itemized bills or medical records to be sent to the payers.

4. Appeals:

    a. Cape will assist with appeals to the insurance company with the patient's permission for resolution of final payment before we drop the balance to the patient. Cape will work with Case Management department if needed on these appeals.

5. Non-appeals:

    a. Cape will contact the patient and explain the process for them to appeal since we cannot perform the appeal on their behalf.
    b. Cape will assist them in the appeals process in any way we can with itemized bills or medical records when necessary.

c. Cape will hold the account for an additional 30 days or until we can speak directly to the patient to get resolution of final payment.
d. After a specified time frame agreed upon by the patient and the business office Cape will drop the balance to the patient's liability. We will set up a contract payment amount for monthly payments agreed upon by the patient and the business office.
e. Subsequent to the Notification Period discussed below (120 days from the date of the first post-discharge billing statement), if a patient misses a payment after 30 days a 48hr letter will be sent to the patient explaining the collection process and the account will then follow the FAP for collections.

Collection Procedures

1. Statements are mailed at no less than 28 day intervals showing the current activity and balance. Each billing statement includes conspicuous written notice which informs the recipient about the availability of financial assistance. The statement also includes the website of where an individual can obtain copies of the FAP, Applications or PLS. Additionally, it includes the telephone number that patients can call if they have questions regarding the availability of financial assistance and the application process.

2. If no payment is made by 31 days after the initial statement the account will be electronically transferred to NPAS for the collection process. NPAS will send 3 data mailers and make phone calls when appropriate. If no payment is made the accounts will be electronically closed and a 48hr letter will be generated by the business office of the hospital explaining to the patient the collection process.

3. Each statement offers the patient a payment plan on the reverse side of the data mailer, a space for credit card information and a space for insurance information.

4. Accounts will be considered for bad debt transfer when they have reached 120 days from the date of the 1st post-discharge billing statement, with exception of bad addresses.

5. After the last statement is sent and there is no response from the debtor, the Managers or Director will review the account for collectability to insure proper pre-collection procedures have been followed. A determination will be made to hold the account in house for an additional period of time for further follow-up, send it to a collection agency or pursue through appropriate legal action.

6. Return mail, whether statement, letter or bill will be documented in the patient's file and investigated for a good address. If Cape is unable to determine a new mailing address, it will be documented in the account and it will be placed for collections.

7. A contract will be established with the patient's written or verbal permission for monthly payments of a set amount.

Credit Arrangements

- Non-emergent services 50% deposit;
- Balance: Under $500.00 due in 90 days;
- Under $1000.00 due in 180 days;
- Under $1500.00 due in 12 months; and

- Greater than $1500.00 not more than 24 months.

Internal Revenue Code Section 501(r)(6)

Cape does not engage in any ECAs as defined by Internal Revenue Code Section 501(r)(6) prior to the expiration of the "Notification Period". The Notification Period is defined as a 120-day period, which begins on the date of the 1st post-discharge billing statement, in which no ECAs may be initiated against the patient.

Subsequent to the Notification Period Cape, or any third parties acting on their behalf, may initiate the following ECAs against a patient for an unpaid balance if a FAP-eligibility determination has not been made or if an individual is ineligible for financial assistance.

a. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus;
b. Deferring, denying or requiring payment before providing medically necessary care because of an individual's nonpayment for previously provided care;
c. Placing a lien on an individual's property; and
d. Garnishing an individual's wages.

Cape may authorize third parties to initiate ECAs on delinquent patient accounts after the Notification Period. Cape will ensure reasonable efforts have been taken to determine whether an individual is eligible for financial assistance under this FAP. Cape must take the following actions at least 30 days prior to initiating any ECA:

1. The patient has been provided with written notice which:

    a. Indicates that financial assistance is available for eligible patients;
    b. Identifies the ECA(s) that Cape intends to initiate to obtain payment for the care; and
    c. States a deadline after which such ECAs may be initiated.

2. The patient has received a copy of the PLS with this written notification; and

3. Reasonable efforts have been made to orally notify the individual about the FAP and how the individual may obtain assistance with the financial assistance application process.

Bad Debt Write-Off

After all the collection procedures have been met all other accounts except:

1. subject to payment plans (contracts);
2. those filed under bankruptcy;
3. medical denials;
4. courtesy allowances;

will be reviewed by a Manager or Director and a determination will be made to (1) hold the account in house or for an additional period of time for further follow up, (2) send to an outside collection agency or (3) pursue through appropriate legal action.

CAPE REGIONAL MEDICAL CENTER
FINANCIAL ASSISTANCE POLICY PHYSICIAN PROVIDER LISTING

Physician Group/Name	Participates in CAPES's Financial Assistance Policy for Services Provided at the Medical Center
American Surgical Arts	No
Beitman, MD, Robert	No
Birk, DPM, Charles	No
Bopf, DPM, Keith	No
Cape Anesthesia and Pain Management	No
Cape Atlantic Gastro Associates	No
Cape Atlantic Oral & Maxillofacial Surgeons, PA	No
Cape Counseling	Yes
Cape Emergency Physicians	No
Cape Heart Clinic	No
Cape May Court House Associates in Radiology	Yes
Cape OB/GYN, Division of Regional Womens Health Group	No
Cape Regional Physicians Associates	Yes
Carey, DPM, Martin	No
Childrens Hospital of Philadelphia - Pediatric Cardiology	No
Childs, DO, Arthur	No
Cho, MD, David	No
Cooper Perinatology Associates	No
DeNittis, MD, Albert	No
East Coast Ortho and Sport Medicine	No
Facciolo, DO, Jack	No
Goldberg, MD, Robert	No
Hansen, DO, Eric	No
Harrison, DO, David	No
Hope Community Cancer Center	No
Komansky, DO, Henry	Yes
Lawinski, MD, Richard	No
Lucasti, DO, Christopher	No
O'Beirne, MD, Patrick	No
Onwuka, MD, Aloysius	No
Pagnani, Braga Kimmel Urologic Assoc, PA	No
Paolini, DO, Lawrence	No
Pastore, MD, Domenic	No

Penn Cardiology	No
Rainbow Pediatrics, PC	Yes
Regional Nephrology Associates	No
Sabnis, MD, Vinayak	No
Salasin, MD, Robert	No
Shah, DO, Chetan	No
Shore Orthopaedic University Assoc.	No
Skinner, MD, Dirk	No
Sorensen, DPM, Timothy	No
Udani, DO, Paras	No
Udani, MD, Rajen	No
University of Pennsylvania - Ortho	No
White, DO, Christian	No