

CASH FLOW NETWORK

Provider Questionnaire – Medical Receivables Funding

Medical Practice Name: _____ DBA: _____

Contact: _____ Title: _____ Phone: _____ Fax: _____

Website: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Name of Principals: _____ SS#: _____ % Ownership: _____

_____ SS#: _____ % Ownership: _____

_____ SS#: _____ % Ownership: _____

How did you hear about our Medical Receivables Funding Program? _____

Type of Entity (Please Circle)

Group / MSO _____
Hospital _____
Nursing Home _____
Specialty _____
Other _____

General Practice
Clinic
DME / HME

Structure (Please Circle)

Corporation (State Inc _____)
S C LLC
Profit / Not for Profit
Partnership
Other _____

Years in Business: _____

Tax ID #: _____

Fiscal Year Ends (month/day/year): _____

Medicare UPIN #: _____

Accounts Receivables Information

Year to Date # of Months _____

Last Fiscal Year

Gross Charges: \$ _____

Gross Charges: \$ _____

Collections *: \$ _____

Collections: * \$ _____

** Do Not Include Co-Payments or Private Pay*

Average # of Claims filed per month: _____

Breakdown of Accounts Receivables by Financial Class

| | | | |
|-----------------------------|---------|--------------------------------------|---------|
| 1. Group Insurance | _____ % | 7. Worker's Compensation | _____ % |
| 2. Private Pay | _____ % | Defense / Employer/Company/Physician | _____ % |
| 3. Blue Cross / Blue Shield | _____ % | Medical – Legal | _____ % |
| 4. HMO / PPO / IPA | _____ % | Treatment | _____ % |
| 5. Personal Injury | _____ % | 8. Other _____ | _____ % |
| 6. Medicare / Medicaid | _____ % | | |

TOTAL _____ %

CASH FLOW NETWORK

Provider Certification

I certify that the information provided in this questionnaire is true and correct as of the date set forth below my / our signature(s) on this questionnaire and authorize Cash Flow Network®, its Affiliate Medical Receivables Funding Company and its agents to verify any information provided herein.

My / our signature(s) authorizes Cash Flow Network®, its Affiliate Medical Receivables Funding Company and its agents to review business and/or personal credit profiles by a reputable Credit Reporting Agency.

Via this consent, Cash Flow Network® and its Affiliate Medical Receivables Funding Company certify that the required credit report(s) will be used for the sole purpose of evaluating this questionnaire and will not be used for any other purpose.

I / we further acknowledge my / our understanding that any intentional or negligent misrepresentation(s) of the information contained in this questionnaire may result in civil liability and / or criminal penalties and liability for monetary damages to the lender, its agents, successors and assigns and any other person(s) who may suffer a loss due to reliance upon any misrepresentation(s) which have been made on this questionnaire.

To process your request in a timely manner, this questionnaire must be completed and signed by each principal.

Attach Additional Sheets if Necessary

I have read, understand and agree to the above certifications.

Name: _____ Signature: _____

Home Address: _____ Date: _____

Name: _____ Signature: _____

Home Address: _____ Date: _____

Name: _____ Signature: _____

Home Address: _____ Date: _____

Name: _____ Signature: _____

Home Address: _____ Date: _____

Thank you for choosing Cash Flow Network and its Affiliate Medical Receivables Funding Network. We look forward to developing a healthy and mutually beneficial relationship.

The staff in our company and affiliate network are available to answer any questions you may have. Do not hesitate to contact us.