



NEW YORK CITY DEPARTMENT OF  
HEALTH AND MENTAL HYGIENE

Mary T. Bassett, MD, MPH

*Commissioner*

Dear Patient:

This letter is to notify you that the New York City Health Department asks for health insurance information or a fee for clinic services given to adults (age 19 and over). The Health Department must ask for insurance or payment for services to meet Medicaid standards and other legal requirements.

- 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.**

For more billing information, visit [nyc.gov/health](https://nyc.gov/health) and search for "clinic billing FAQ" or call 311 and ask about "health department clinic billing." If you have any questions, please ask clinic staff.

Sincerely,

A handwritten signature in black ink that reads "Mary T. Bassett".

Mary T. Bassett, MD, MPH  
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 house, 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 to 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 \$17,235	\$17,236 to \$22,980	\$22,981 to \$28,725	\$28,726 to \$34,470	\$34,471 to \$40,215
2	Under \$23,265	\$23,266 to \$31,020	\$31,021 to \$38,775	\$38,776 to \$46,530	\$46,531 to \$54,285	Over \$54,286
3	Under \$29,295	\$29,296 to \$39,060	\$39,061 to \$48,825	\$48,826 to \$58,590	\$58,591 to \$68,355	Over \$68,356
4	Under \$35,325	\$35,326 to \$47,100	\$47,101 to \$58,875	\$58,876 to \$70,650	\$70,651 to \$82,425	Over \$82,426
5	Under \$41,355	\$41,356 to \$55,140	\$55,141 to \$68,925	\$68,926 to \$82,710	\$82,711 to \$96,495	Over \$96,496
6	Under \$47,385	\$47,386 to \$63,180	\$63,181 to \$78,975	\$78,976 to \$94,770	\$94,771 to \$110,565	Over \$110,566
7	Under \$53,415	\$53,416 to \$71,220	\$71,221 to \$89,025	\$89,026 to \$106,830	\$106,831 to \$124,635	Over \$124,636
<b>Fees</b>	<b>\$0</b>	<b>\$15</b>	<b>\$20</b>	<b>\$30</b>	<b>\$40</b>	<b>\$50</b>

**Fee Scale Examples:**

- A single person (family size of 1) with a yearly income of \$28,000: \$20 due.
- A person living with 3 children, a spouse and a parent (family size of 6), with a yearly income of \$85,000: \$30 due.

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

If you did not bring your insurance card today, please fill out the bottom of this page and submit it to the mailing address below.

If you gave your insurance information at the clinic or are submitting it by mail, you or the policy holder may receive an Explanation of Benefits (EOB) from your insurance provider. The EOB will list the services you received and show if a copayment is required. If you owe a copayment, please mail a check or money order (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 28<sup>th</sup> Street, CN 32W  
 Long Island City, NY 11101



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

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: \_\_\_\_\_