尊敬的患者：

此函是要通知您，紐約市衛生局(New York City Health Department)為成人(年滿19歲及以上) 提供的診所服務可能要求健康保險資訊或收取費用。衛生局必須要求相關服務的保險或付款，以符合聯邦醫療補助(Medicaid)的標準與其他法律要求。

- 如果您沒有健康保險或是不想向您的保險開立此訪視的帳單，請參閱A小節。
- 如果您想使用您的健康保險來支付此訪視，請參閱B小節。

如果您沒有健康保險或無法支付費用，您仍然可以取得服務。

如需更多關於計費的資訊，請造訪nyc.gov/health並搜尋「診所計費常見問題集」("clinic billing FAQ")或致電311並詢問關於「衛生局診所計費」。若您有任何疑問，請詢問診所工作人員。

誠摯的，

Mary T. Bassett, MD, MPH
局長
A. If you do not have health insurance or do not want to bill your insurance, please use floating calculation.

1. From the "Family Members" column, find the number of family members living at your house, including yourself.

2. Cross-reference and find your annual income. No proof of family members or annual income will be required.

3. Look at the bottom of the column and check how much you owe.

4. Fill out a check or cashier's check (non-cash), payable to NYC Department of Health and Mental Hygiene.

5. On the check or cashier's check, note the patient's name, visit date and patient ID number (appearing on the front of the label). The mailing address is as follows.

### Floating Calculation

<table>
<thead>
<tr>
<th>Family Members</th>
<th>Income Range</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$16,643 to $18,093</td>
<td>$0</td>
</tr>
<tr>
<td>2</td>
<td>$18,094 to $30,150</td>
<td>$15</td>
</tr>
<tr>
<td>3</td>
<td>$30,151 to $36,180</td>
<td>$20</td>
</tr>
<tr>
<td>4</td>
<td>$36,181 to $48,240</td>
<td>$30</td>
</tr>
<tr>
<td>5</td>
<td>$48,241 to $64,960</td>
<td>$40</td>
</tr>
<tr>
<td>6</td>
<td>$64,961 to $81,680</td>
<td>$50</td>
</tr>
</tbody>
</table>

**Example:**
- An annual income of $28,000 for a single person (family members 1): $20.
- With 3 children, spouse, and parents (6 family members), an annual income of $85,000: $30.

B. Use your health insurance to pay for this visit:

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

If you submitted insurance information at the clinic or mailed it, you or the insured may receive a benefit explanation from your insurance provider (Explanation of Benefits, EOB). EOB will list the services you received and show whether you owe a copayment. If you owe a copayment, please mail a check or cashier's check (non-cash), payable to

**NYC Department of Health and Mental Hygiene**

Mail to the following address. On the check or cashier's check, note the patient's name, visit date and patient ID number (appearing on the front of this document).

**Mail Address:**

NYC Department of Health and Mental Hygiene
Attn: Division of Finance
42-09 28th Street, CN 32W
Long Island City, NY 11101

---

Please send my visit to the following insurance provider:

Insurance Provider Name: __________________________________________

Insurance Provider Address: ________________________________________

Insurance Provider Phone Number: ________________________________

Insurance ID: ____________________________________________ Group Number: __________________________

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

Insured Name: ______________________________________ Insured Date of Birth: __________________________

Relationship: ( ) spouse ( ) parent ( ) other

Signature: ______________________________________ Date: ________________