Premier Small
Business Solutions, *LLC*

Health Care Factoring Application

Fax To: (866) 240-8454

Health Care Factoring Application

Copy of the Articles of Incorporation or Partnership Agreement

Copy of the most recent summary of billing aging statement

Most recent financial statements (Balance Sheet and P & L)

Copy of the Providers medical license if applicable

Please include all information above
Return completed application and documents via fax

Legal Name of entity on Articles of Incorporation: _____

DBA if applicable: _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-Mail Address _____Federal Tax ID #_____

If the Company uses a d/b/a or trade style, what is it? _____

Company is a ____ Corp ____Legal Partnership ____Proprietorship ____ LLC Other_____

Date Business Started: _____ /_____ /_____ State of Incorporation / Registration _____

Describe Type of Business: _____

Information on your Business / Practice

What is your average monthly billing volume? $ _____

How much of your average monthly billing do you wish to factor? $ _____

(Check one) Monthly billing administration _____ Internally processed _____ Outsourced

Have you ever factored your receivables? _____ No ____Yes

If yes, with whom? _____

(Check one) Collection procedures _____Internally administered _____Outsourced

Does the Applicant or its Principal(s) have any judgments or liens filed against them? _____ No_____ Yes

If yes, please explain: _____

Does the Applicant or its Principal(s) have any pending lawsuits against them? _____No _____Yes

If yes, please explain: _____

Are your Payroll, Federal and State Income Taxes Current? _____ Yes_____ No

If No, please explain: _____

How much bad debt did you write off last year? $ _____

Is there any security interest granted that covers your medical accounts receivable? _____

If yes, please explain: _____

Do you have any outstanding business or practice loans? _____ No _____ Yes

If yes, with whom? _____

Name of Financial Institution: _____

Address of Financial Institution: _____

Balance owed $ _____ Contact Name: _____

Phone ( )_____ Fax: ( ) _____

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Bank Account(s)

Bank Name: _____ Account # _____

Contact Name: _____ Phone: _____

Bank Name: _____ Account # _____

Contact Name: _____ Phone: _____

Billings Outstanding by Class and Date
Please estimate figures for your facility(s)

Payer Class	Days Outstanding						
	0-30	31-60	61-90	91-120	121-150	151-180	180+
Medicare -							
Medicaid -							
Blue Cross/Shield							
Commercial Ins.							
HMO/PPO							
Self-Pay							
Workers Comp.							
Other (Specify)							

Ownership Disclosure

Officer Name/Title _____ **Home Address (city, state, Zip)** _____

Home phone _____ **Social Security #** _____ **Ownership** % _____

Medical Provider License Number _____ **State of Issue** _____ **Date of Issue** _____

Officer Name/Title _____ **Home Address (City, State, Zip)** _____

Home phone _____ **Social Security #** _____ **Ownership** % _____

Medical Provider License Number _____ **State of Issue** _____ **Date of Issue** _____

The individuals named below, as owners or proposed guarantors of Customer, authorize *Premier Small Business Solutions, LLC or its assignee(s)* to conduct such investigations and inquires as to the Customer's and individuals' credit, operations and collateral, as shall be deemed necessary or desirable by *Premier Small Business Solutions, LLC or its assignee(s)* in connection with the credit application. Customer also agrees to advise persons of whom *Premier Small Business Solutions, LLC its assignee(s)* may make such inquiry to cooperate with and supply all requested information, unless *Premier Small Business Solutions, LLC or its assignee(s)* is specifically advised otherwise by Customer. A photographic or faxed copy of this authorization shall be as valid as the original.

Agreed and Consented to by:

Signature: _____ **Title:** _____

Print Name: _____ **Date**_____/_____/_____

Medical Malpractice Insurance Disclosure

In addition to application, we require the following information:

Malpractice Insurance Carrier:

NAME_____

ADDRESS_____

CITY_____

STATE_____ZIP_____

POLICY #_____

EFFECTIVE DATE_____

Please attach a copy of insurance documentation along with your Medical License.

I/we grant *Premier Small business Solutions, LLC* ***and or its assignee(s)*** the right to procure any and all reports pertaining to the above Medical Malpractice Insurance. A photographic or faxed copy of this authorization shall be as valid as the original.

Agreed and Consented to by:

Signature_____ Title_____

Print Name_____ Date_____