The Funding Source Network ~ Medical Receivable Application

San Jose, CA 95128 Bus:(408) 294-8736 Cell:(408) 396-3337 Email: rlevans@fundingsourcenetwork.com

Information on your Business / Practice

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:

_____

_____

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?

Banking & Financial Information

Name of Financial Institution: _____

Address of Financial Institution: _____

Balance owed $ _____

Contact Name: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Bank Account(s)

Bank Name: _____ Account # _____

1. Contact Name: _____Phone: (_____) _____ - _____
2. Contact Name: _____Phone: (_____) _____ - _____

Billings Outstanding by Class and Date

Please estimate figures for your facility(s)

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

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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 foregoing information is true and correct to the best of my knowledge and is given to The Funding Source Network and its funding sources to consider entering into a factoring agreement with one of these funding sources. I do hereby authorize The Funding Source Network or its agents the right to verify and investigate any and all of the foregoing statements, including, but not limited to, my/our credit worthiness and financial responsibility, in any way it may choose. I/we grant The Funding Source Network and its funding sources the right to procure any and all reports pertaining applicant and any party listed in this application, including but not limited to, all principals of the applicant company.

Agreed and Consented to by:

Signature: _____
Title: _____

Print Name: _____ Date: ____/____/____

The documents requested in this application contain confidential information belonging to the applicant, which is protected by state and/or federal regulations. This information is intended only for the use of The Funding Source Network and its funding sources and any disclosure, copying, distribution, or the taking of any action based on the contents of this information is strictly prohibited.

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Malpractice Insurance Disclosure

In addition to the this 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 The Funding Source Network and its funding sources the right to procure any and all reports pertaining to the above Medical Malpractice Insurance.

Agreed and Consented to by:

Signature: _____Title: _____

Print Name: _____Date: _____