#### [*Sample]* Aging Report

## XXXXX HEALTH DEPARTMENT

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Director

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Administrative Services Manager

FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic/ Support Services Manager

#### RE: Monthly Aging Report

 *Request to write-off and/or adjustment to the following Payor Code Accounts that are either twelve (12) months or more past due, or have been determined non-reimbursable through listed payor source in Accounts/Receivable (A/R).*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **LHD Name** | **# of Invoices** | **12 mo. Overdue amt./non-reimbursable** | **Approved** | **Denied** |
| Payor Code 1 (Self-Pay) |  |  |  |  |
| Payor Code 2 (Medicaid)  |  | *This example can be used to assist you in establishing a standard procedure for the collection and management of receipts, to include write-offs, to ensure adequate and appropriate internal control measures.*  |  |  |
| Payor Code 3 (Medicare)  |  |  |  |  |
| Payor Code 8 (Contract) |  |   |  |  |
| Payor Code 9 Insurance) |  |  |  |  |
| **TOTAL** |  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Director of Administrative Services Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Public Health Director Date