NOBLE FINANCE$:
Accelerating CA$H Flow

MEDICAL ACCOUNTS RECEIVABLE FUNDING APPLICATION

Noble Finance$
4355 Cobb Pkwy, Ste J-217, Atlanta GA 30339
Tel: (404) 374-3384

Required Documents

The approval process consists of two phases. The first is the application process. During this phase we will require you to complete the attached application and provide us with the documents listed in category #1 below. Once we complete the review of the documents you submit, we will contact you regarding your eligibility.

If your organization meets our initial underwriting qualifications, we will send you a Letter of Intent (LOI) that will quote our discount fee, advance rate and other terms and conditions of a proposed transaction The LOI is the first step in the second phase and must be sent back signed, along with the Category #2 documents listed below. We suggest that you immediately begin preparing the items under Category #2, as we will complete the first part of our due diligence rather quickly and (if applicable) will be sending you the LOI immediately thereafter.

Upon review of the remaining documents and our determination of a) the Net Collectible Value of your claims and b) the systems and controls established and used by your organization, your final eligibility will be determined. If approved, we will then move on to establishing the funding procedures, and ultimately begin your funding. ***Note: Each transaction is unique and there may be other information needed to complete our due diligence.***

Although the list looks somewhat lengthy and detailed, your in-house systems (or those of your billing company) should easily generate most of these reports.

Category #1) Upon completion of the attached application please submit it along with the following:

- A/R Aging Summary by Payor
- Business Name Verification (Articles of Inc., DBA filing, etc.)
- Medical License Verification
- Current Detailed Aging – Computer Generated containing;
  1) Patient Name
  2) Procedure Code Billed
  3) Dates of Service
  4) Charges
  5) Insurance Carrier Billed

- Computer generated six month Closed History reflecting:
  -Legend if codes were used for adjustments
  -File format with the ability to be manipulated not a "read only" file ("excel" preferred).
  1) Include name of primary carrier that was billed
  2) Patient name
  3) Date of service
  4) CPT code
  5) Amount billed
  6) Amount collected
  7) Adjustments
  8) Date claim was paid.
- Copies of Federal, State and local Payroll tax returns for most recent two quarters (any correspondence from IRS) & supporting proof of payment.
- Copies of Financial Statements for the most recent fiscal or two calendar years along with any interim quarterly reports issued subsequent to close of most recent year.
- A complete computerized listing of all the third party payors that you bill (names and addresses)
- Copy of your organization's Policies & Procedures for billing, collecting and registration.
- Copies of any significant insurance carrier contracts that are currently being used for billing along with a complete list of expiration dates.
- Copy of Loss Run from malpractice / liability insurance carriers.

Category #2) Upon your receipt, signature and return of the Letter of Intent, please include the following:

- Bank Statements for each account for the months listed on the Letter of Intent
- Copies of daily deposit slips or notices of electronic transfers with corresponding copies of EOB's attached. Have these in chronological order and in itemized order with deposit slip
- Copies of all correspondence and reports and paybacks resulting from audits, reviews, surveys or inquiries from Medicare, the fiscal intermediary, the state department of health, the state department of social services the Medicare Fraud Control Unit, or any other state or federal agency or third party payor. Please provide complete details of any settlements, withholds paychecks, etc. that have been made or are contemplated. NOTE:

Forms will be submitted to:

SUN CAPITAL HealthCare, Inc.
The Healthcare Industry's Foremost Funding Source

Sun Capital HealthCare, Inc.
929 Clint Moore Road, Boca Raton, Florida 33487
Tel: (800) 880-1709 ~ Fax: (800) 645-1942

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Please include ALL information requested, otherwise application process will be delayed

Legal Name of entity on Articles of Incorporation: _____

Dba if applicable: _____

Federal Tax ID # _____ Medicare Provider #_____

If more than one legal entity: Name_____Tax ID_____

Name_____Tax ID_____

Address _____

City _____ State _____ Zip _____

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

Primary Contact Name _____Phone (_____) _____ - _____Email_____

Secondary Contact Name _____ Phone (_____) _____ - _____Email_____

Web Site _____

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

Who is your billing company? _____Contact Name:_____Phone (_____)_____

If internal, what software are you using for billing/AR? _____

Is your company presently capable of transmitting billing information electronically? _____ No _____ Yes

What is your average monthly gross billing volume $ _____ Average net collectible percent_____

How much of your average monthly billing do you intend to factor each month? $ _____

(*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

Has the Applicant or its Principal(s) ever been arrested or convicted of a felony? _____ No _____ Yes

If Yes, please explain_____

Does the Applicant or its Principal(s) have any judgments, liens or pending lawsuits filed against them? _____ No _____ Yes

If Yes, please explain: _____

Has the Applicant or its Principal(s) ever filed for bankruptcy? _____ No _____ Yes

If Yes, please explain: _____

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

If No, please explain: _____

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

Has the Applicant or its Principal(s) granted any security interest in 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 (_____) _____ - _____

Information Systems: IT Director

Name _____

Phone (_____) _____ - _____

Email _____

Attorney

Name _____

Phone (_____) _____ - _____

Email _____

Bank Account(s)

Bank Name: _____ Account # _____
Address _____ Account # _____
City,ST Zip _____ Account # _____

Contact Name: _____ Phone (_____) _____ - _____

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 Sun Capital HealthCare, Inc. to induce Sun Capital to consider entering into a factoring agreement with this company Or provider I/we do hereby authorize Sun Capital exclusively 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 Sun Capital HealthCare, Inc. exclusively the right to procure any and all reports including but not limited to credit reports and background investigations pertaining to 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 Sun Capital HealthCare, Inc. and any disclosure, copying, distribution, or the taking of any action based on the contents of this information is strictly prohibited.

SUN CAPITAL HealthCare, Inc.

The Healthcare Industry's Foremost Funding Source

Sun Capital HealthCare, Inc.

929 CLINT MOORE ROAD, BOCA RATON, FL 33487
Tel: (561) 995-9615 / Fax: (561) 994-4937
Tel: (800) 880-1709 / Fax: (800) 645-1942

Malpractice Insurance Carrier:

NAME_____

ADDRESS_____

CITY_____

STATE_____ZIP_____

POLICY #_____

EFFECTIVE DATE_____

Please attach a copy of insurance documentation.

Have you, within the last two years, received correspondence and reports from audits, reviews, surveys, or inquiries by Medicare, the fiscal intermediary, state dept. of health, social services, frauds control unit, or any other state or federal agency or third party payor? _____
If yes, please attach details.

I/we grant Sun Capital HealthCare, Inc. 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_____

Referring Broker's name _Sandra Noble_____ Telephone Number _404-374-3384_____