



Fax: 412-578-3285

To:	From:
Fax:	Pages: (including cover)
Phone:	Date:
Re:	CC:

Introduction:

The Family House Third Party Billing Authorization form is attached. Please complete, sign and fax the form to the Family House Housing office.

Organization:

Family House provides a "home away from home" for patients and their families who must travel to Pittsburgh for medical treatment. It is accessible and affordable, offering comfort, compassion, and hospitality.

Founded in 1983, Family House, Inc. is a non-profit, 501 (c) (3), corporation governed by a voluntary Board of Directors. Our mission is to serve patients and the families of those patients undergoing treatment at local hospitals.

Purpose of form:

The purpose of this form is to establish pre-arrival authorization for a third party to cover all or a portion of the guest's stay. If the guest and case worker complete the pre-arrival authorization, Family House will know that payment is pending and the guest's room can be reserved. The following guidelines should be adhered to:

- ❖ Prior to their arrival at Family House, the guest must call Family House and send written authorization from the third-party payer to the Housing Coordinator for the covered time period of the guest's stay.
- ❖ In case of an unplanned arrival, an authorization phone call must be received within three (3) days of arrival with a follow-up written authorization. If this authorization is not received, the guest will be expected to make payment on their stay until full authorization is received.
- ❖ The following Third Party Billing Authorization form should be utilized by the guests and their home-based case worker when establishing authorization.

5308 Liberty Ave Pittsburgh PA, 15224

Phone: 412-647-7777

THIRD PARTY BILLING AUTHORIZATION

Nightly Rates:

**(Twin : \$75), (1Q,1K,2T: \$99), (2TDSB/1QDSB: \$116), (2Q: \$116), (2QDSB: \$125), (2T/Q Kitchenette : \$130)
(Appartement 1K DSB : \$148)**

This is to confirm that _____ will cover the cost of housing for _____
(PRINT third party payer) (PRINT guest name)

at a rate of \$ ____ per night at Family House.

Anticipated Arrival Date: _____

Select One:

____ For maximum of _____ days, or \$ _____ dollar ---OR---

____ This is an unlimited fund _____ (Please initial if unlimited)

Third Party Payments must be made by the Third Party directly to Family House within 30 days upon receipt of invoice.

Note: Family House will not accept a Third Party Reimbursement from the guest.

Authorization:

Signature of third party payer: _____ Date: _____

Third Party Payer Contact Name: _____
Please print

Address: _____

Phone Number: _____ Fax number: _____

E Mail: _____

Credit Card # _____ Expiration Date: _____

SEC Code: _____ Zip code of Card Billing _____ Name on Card _____