



Thank you for your interest in Medical Receivable Finance through The Coastal Capital Group.

Please submit the following documents along with the completed application:

1. Most recent AR and AP aging
2. Current Financials
3. Previous two years financials
4. List of insurance companies you are currently working with
5. Collection history report for the last 12 months broken down by procedure showing Date of Service Date of Bill, Amount Billed, Insurance Carrier, Payment made by Insurance, Payment made by Patient, Write Off/Adjustment, Balance.



MEDICAL ACCOUNTS RECEIVABLE FACTORING APPLICATION
BUSINESS INFORMATION

Legal Name of entity on Articles of Incorporation _____

Trade Names (DBA's) if applicable _____

Federal Tax ID # _____ Medicare Provider # _____ NPI _____

If more than one legal entity: Name _____ Tax ID _____

Name _____ Tax ID _____

Address _____ City _____ State _____ Zip _____

Previous address if current less than three (3) years: _____

Primary Contact _____ Email _____

Phone (____) ____ - ____ Fax (____) ____ - ____ Website _____

Company is a Corporation _____ Partnership _____ Sole Proprietorship _____ LLC _____ Other _____

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

Has the name of the company changed within the last two years? ____ NO ____ YES (If "yes" please provide previous name) _____

Has ownership changed within the last two years? ____ NO ____ YES (If "yes" please provide details) _____

Describe Type of Business _____

How many employees do you have? _____ Do you have multiple offices? ____ NO ____ YES (If "yes" please provide locations) _____

LEGAL ENVIRONMENT

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

Does the Company or its Principal(s) have any judgments or lawsuits filed against them? ____ No ____ Yes

Has the Company or its Principal(s) ever filed for bankruptcy? ____ No ____ Yes

Are there any Security Interest granted (UCC's Filed) against the Company or its Principal(s)? ____ No ____ Yes

Do you have outstanding/unpaid Payroll, Federal or State Income Taxes Liabilities? ____ No ____ Yes

Do you have any Installment Agreements for Payroll, Federal or State Income Taxes? ____ No ____ Yes

If YES to any answer above, please provide details _____





OWNERSHIP DISCLOSURE (If there are additional principals, provide details on a separate sheet of paper)

Officer Name/Title _____ Social Security # _____
Home Address _____ Home Phone (____) ____ - ____ Ownership _____%
Medical Provider License # _____ State of Issue _____ Date Issued _____
Has this person ever owned or been part owner in another company? If so, please furnish the complete legal name, address, and any DBA's of that company: _____

Officer Name/Title _____ Social Security # _____
Home Address _____ Home Phone (____) ____ - ____ Ownership _____%
Medical Provider License # _____ State of Issue _____ Date Issued _____
Has this person ever owned or been part owner in another company? If so, please furnish the complete legal name, address, and any DBA's of that company: _____

Officer Name/Title _____ Social Security # _____
Home Address _____ Home Phone (____) ____ - ____ Ownership _____%
Medical Provider License # _____ State of Issue _____ Date Issued _____
Has this person ever owned or been part owner in another company? If so, please furnish the complete legal name, address, and any DBA's of that company: _____

BASIC PROCEDURES INFORMATION

Have you, within the last two years, received correspondence and reports from audits, reviews, surveys, or inquiries by Medicare, the Fiscal Intermediary, State Department of Health, Social Services, Frauds Control Unit, or any other State or Federal agency or third party payor? _____ NO _____ YES (If "yes" please provide details) _____

Who is your billing company? _____
Contact Person at the billing company _____ Phone (____) ____ - ____
If internal, what software are you using for billing/AR? _____
Is your company presently capable of transmitting billing information electronically? _____ NO _____ YES
Is your monthly billing administration: _____ Internally processed _____ Outsourced
Are your collection procedures: _____ Internally administered _____ Outsourced

Bank Account(s): (If more space is needed, please provide details on a separate sheet of paper)

Bank Name _____ Address _____
ABA _____ Account # _____

Bank Name _____ Address _____
ABA _____ Account # _____

Bank Name _____ Address _____
ABA _____ Account # _____





Malpractice Insurance Carrier:

Name _____ Address _____
Contact Name _____ Phone (____) ____-____ Email _____
Policy # _____ Effective Date _____

ACCOUNTS RECEIVABLE INFORMATION

What is your average monthly gross billing volume \$ _____ Average net collectible percent _____%

Amount of open receivables (Total outstanding in GROSS Amount): \$ _____

Aging of receivables (GROSS Amount):
0-30 days: \$ _____
31-60 days: \$ _____
61-90 days: \$ _____
Over 90 days: \$ _____

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

Has the company or its principals currently or previously factored their receivables? _____ No _____ Yes, If YES, with whom? _____

Do you have any outstanding business/ practice loans? _____ No _____ Yes, Balance owed \$ _____

Name of Financial Institution: _____

Contact Information _____

Specific reason why you are applying for this accounts receivable finance facility _____

How did you hear about us? _____

The foregoing information is true and correct to the best of my knowledge and is given to Coastal Capital Group, Inc., (CCG) its affiliates, funding partners, third party underwriters and investors to induce CCG to consider entering into a factoring agreement with this company or provider. I/we do hereby authorize Coastal Capital Group, Inc., its affiliates, funding partners, third party underwriters and investors 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 Coastal Capital Group, Inc., its affiliates, funding partners, third party underwriters and investors 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. I/we grant Coastal Capital Group, Inc., its affiliates, funding partners, third party underwriters and investors the right to procure any and all reports pertaining to the above Medical Malpractice Insurance.

After review of your application, CCG will determine which of its affiliates will be best suited to meet your financing needs, and by signing below you consent to CCG sharing this application and the supplied information with its affiliates. By signing below, you consent to CCG or one or more of its affiliates to file a UCC-1 financing statement against the undersigned describing the collateral secured as "All assets of the Debtor, now existing and hereafter arising, wherever located", or other "all asset" collateral description.

Agreed and Consented to by:

Signature _____ Title _____
Print Name _____ Date _____

