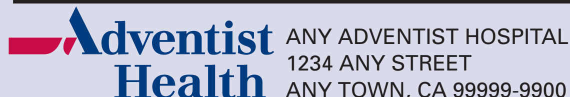
YOUR STATEMENT 5/10/2007



ANY ADVENTIST HOSPITAL
1234 ANY STREET
ANY TOWN, CA 99999-9900

SUMMARY OF INPATIENT SERVICES

Description		Amount
Pharmacy		$ 45.00
Laboratory		223.00
Radiology		125.00
Supplies		255.00
Total Patient Services		$648.00
Insurance payment	04/30/07	$400.00-
Insurance discount	04/30/07	$198.00-
Total Payments & Adjustments		$598.00-
Current Account Balance		**$ 50.00**

IMPORTANT MESSAGE:

YOUR INSURANCE HAS PROCESSED YOUR CLAIM. THIS BALANCE IS YOUR RESPONSIBILITY. PLEASE MAKE YOUR PAYMENT TODAY OR CONTACT US TO DISCUSS FINANCIAL ARRANGEMENTS.

ACCOUNT SUMMARY

Patient	John Patient
Date(s) of Service	04/17/07-04/20/07
Account Number	12345670
Physician	John Doe

INSURANCE INFORMATION

Primary	Medicare
Subscriber	John Q. Patient
ID Number	XXXXX-9999
Secondary	Anthem Blue Cross
Subscriber	John Q. Patient
ID Number	XXXXX-9999

QUESTIONS? (800) 555-5555

For questions about your account, call Customer Service at (800) 555-5555.

Financial Assistance:
Adventist Health provides discounts to eligible low-income patients. If you can't pay part of your bill, please contact our Customer Service Department. We will review your financial situation to determine if you are eligible for financial assistance.

SEPARATE PHYSICIAN BILLING You may receive separate bills from physicians who provided care or who consulted on your case.

931473 (04/08)

ANY ADVENTIST HOSPITAL
PO BOX 9900
ANY TOWN, CA 99999-9900

0101

THANK YOU FOR ALLOWING ANY ADVENTIST HOSPITAL TO PROVIDE FOR YOUR RECENT HEALTHCARE NEEDS.

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

CHECK CARD USING FOR PAYMENT / MARQUE LA TARJETA QUE USARÁ PARA PAGAR		
☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS		
CARD NUMBER / NÚMERO DE TARJETA		SIGNATURE CODE / CÓDIGO DE LA FIRMA
SIGNATURE / FIRMA		EXP. DATE / FECHA DE VENCIMIENTO
PATIENT NAME / NOMBRE DEL PACIENTE		**DATE DUE / FECHA DE PAGO**
JOHN Q. PATIENT		5/24/2007
ACCOUNT NUMBER / NÚMERO DE CUENTA	**AMOUNT DUE / SALDO A PAGAR**	**AMOUNT PAYING CANTIDAD REMITIDA**
12345670	$50.00	$

MAKE CHECKS PAYABLE TO

JOHN Q. PATIENT
1234 MAIN ST
ANYTOWN, USA 12345-6789

ANY ADVENTIST HOSPITAL
PO BOX 9900
ANY TOWN, CA 99999-9900

00000300053287600000000001560099999   1317*S3I0XAAV0000001   AA

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE . . . .

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)		
ADDRESS		
CITY	STATE	ZIP
TELEPHONE		

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME		EFFECTIVE DATE
PRIMARY INSURANCE COMPANY'S ADDRESS		PHONE
CITY	STATE	ZIP
POLICYHOLDER'S ID NUMBER	GROUP PLAN NUMBER	
YOUR SECONDARY INSURANCE COMPANY'S NAME		EFFECTIVE DATE
SECONDARY INSURANCE COMPANY'S ADDRESS		PHONE
CITY	STATE	ZIP
POLICYHOLDER'S ID NUMBER	GROUP PLAN NUMBER	