Patient Financial Services Statement Specifications

Form Specifications (Section I thru IV)

SECTION I: JOHN DEMPSEY HOSPITAL SPECIFICATIONS

Subsection A: Statements

1. Weekly electronic file is produced by University of CT Health Center (UCHC).
6200 BPI EBCDIC
Reel Block size 2048
Variable Block 10 characters per inch
Black Ink
Laser printing, folding, stuffing of weekly billing statements for John Dempsey Hospital via electronic file. Stock paper and envelopes shall be provided by supplier.
2. Approximately 3,500 - 5,000 patient accounts are on a weekly run. The total of all individual pages is approximately 6,800 pages. **Vendor shall laser print the information on one-sided 8-1/2" x 11" cut sheet. Reverse side of each sheet will have fixed template information.** Subsequent pages are in the same format **(see Attachment #1). Vendor shall assume programming costs associated with printing information in correct location on statement and running column lines.**
3. 12 pitch print, black ink onto one sided 8-1/2" x 11" page. **Reverse side of each sheet will have fixed template information.**
4. Presort first class mailing. (Supplier is responsible to bill us for postage)
5. Agency shall to use #9 return envelope and #10 mailing envelopes.
6. Laser printing, folding, stuffing of monthly billing statements on 8-1/2" x 11" cut sheet forms. For multiple page bills, the second and subsequent pages shall be a difference format, requiring the ability to print on two different formats; one color, one side.
7. All electronic files shall be produced by the University of CT Health Center (UCHC). This shall include sorting, coding for automatic matching of multi-page statements, changing forms, etc. Vendor to automatically match and sent multipage statement through the use of intelligent inserting equipment. Include up to two (2) inserts with specified statements.
8. The electronic file is produced by John Dempsey Hospital every Thursday or the next available business day.
9. Any addresses that need corrections should be sent back, in copy form, to John Dempsey Hospital for correction to our database.
10. Vendor shall guarantee forty-eight (48) hour turnaround time.
11. Vendor shall notify John Dempsey Hospital via e-mail of the following:

- Date file is received.
- Date statements mailed.
- Number of statements mailed

12. Samples of pages 1 and 2 of the statement attached.

Subsection B: Letters

1. Laser printing, folding, stuffing of letters for John Dempsey Hospital via electronic file. Price to also include stuffing return envelope.
2. Stock paper and envelopes shall be provided by supplier.
3. Volume to be determined based on need.
4. Black ink
5. Letter: one-sided 8-1/2" x 11" perforated (see attached example).
Mailing envelope: 4-1/4" x 9-1/2"
Return envelope: 3-7/8" x 8-7/8"
6. Presort first class mailing. (Supplier is responsible to bill us for postage)
7. Mailing shall occur within 48 hours of receipt.
8. Form is subject to change.

SECTION II: UNIVERSITY DENTISTS SPECIFICATIONS

Subsection A: Statements

1. Laser printing, folding, and stuffing of monthly billing statements which are run during the 1st week of the month for University Dentists via a text file that is transferred to a secured website that is only accessible with a password provided by the vendor. Stock paper and envelopes shall be provided by supplier.
2. Approximately 1,000 to 3,000 statements printed per month. 90% are single page, 10% more than two pages. **Reverse side of each sheet will have fixed template information.**
3. 12 pitch print, black ink onto one sided 8-1/2" x 11" page. **Reverse side of each sheet will have fixed template information.**
4. Presort First Class mailing. (Supplier is responsible to bill us for postage)
5. #10 mailing envelopes.
6. Laser printing and stuffing of monthly billing statements on 8-1/2" x 11" cut sheet forms. **Reverse side of each sheet will have fixed template information.** For multiple page bills, the second and subsequent pages shall be a different format, requiring the ability to print on two different formats; one color, one side.
7. All statement files shall be produced by the University of CT Health Center (UCHC). This shall include sorting, coding for automatic matching of multi-page statements, changing forms, etc. Vendor to automatically match and send multipage statement through the use of intelligent inserting equipment. Vendor to

open and process files, the day after each statement run – within 1 business day of receiving files.
8. Include up to two (2) inserts with specified statements.
9. The price shall not increase if University Dentists switches from a monthly to a weekly billing cycle.
10. Any addresses that need corrections should be sent back, in copy form, to University Dentists for correction to our database.
11. Vendor shall guarantee forty-eight (48) hour turn-around time.
12. Date special billing returned to University Dentists via courier - Account Status: Hold/Budget.
13. Samples of the University Dentists Statement (side 1 and 2) attached.
14. Vendor to notify University Dentists administration via email of the following:

- Date and Number of Statements mailed

Subsection B
Vendor may also submit a bid to include a complete package of laser printing and mailing statements to include cost of stock paper, printing, stuffing, postage, mailing envelopes, and return envelopes.

SECTION III: SCHOOL OF DENTAL MEDICINE SPECIFICATIONS

Subsection A: Statements
1. Laser printing, folding, and stuffing of monthly billing statements which are run during the 1st week of the month for the School of Dental Medicine via a text file that is transferred to a secured website that is only accessible with a password provided by the vendor. Stock paper and envelopes shall be provided by supplier.
2. Approximately 2,000 to 4,000 statements printed per month. 95% are single page, 5% more than two pages.
3. 12 pitch print, black ink onto one sided 8-1/2" x 11" page. **Reverse side of each sheet will have fixed template information.**
4. Presort First Class mailing. (Supplier is responsible to bill us for postage)
5. #10 mailing envelopes.
6. Laser printing and stuffing of monthly billing statements on 8-1/2" x 11" cut sheet forms. **Reverse side of each sheet will have fixed template information.** For multiple page bills, the second and subsequent pages shall be a different format, requiring the ability to print on two different formats; one color, one side.
7. All statement files shall be produced by the University of CT Health Center (UCHC). This shall include sorting, coding for automatic matching of multipage statements, changing forms, etc. Vendor to automatically match and

send multi-page statement through the use of intelligent inserting equipment. Vendor to open and process files, the day after each statement run – within 1 business day of receiving files.
8. Include up to two (2) inserts with specified statements.
9. The price shall not increase if the School of Dental Medicine switches from a monthly to a weekly billing cycle.
10. Any addresses that need corrections should be sent back, in copy form, to the School of Dental Medicine for correction to our database.
11. Vendor shall guarantee forty-eight (48) hour turn-around time.
12. Date special billing returned to Dental Finance via courier - Account Status: Hold/Budget.
13. Samples of the School of Dental Medicine Statement (sides 1 and 2) attached.
14. Vendor to notify School of Dental Medicine administration via email of the following:

- Date and Number of Statements mailed

Subsection B
Vendor may also submit a bid to include a complete package of laser printing and mailing statements to include cost of stock paper, printing, stuffing, postage, mailing envelopes, and return envelopes.

SECTION IV.: UNIVERSITY PHYSICIANS SPECIFICATIONS

Subsection A: Statements
1. The files are produced by University of CT Health Center (UCHC).
File organization: Sequential
Record format: Variable length, maximum 512 bytes, longest 512 bytes
Record attributes: Carriage return carriage control
2. Approximately 3,500 patient accounts via a weekly electronic file. The total of all individual pages is approximately 6,800 pages. **Vendor shall laser print the information on one-sided 8-1/2" x 11" cut sheet form. Reverse side of each sheet will have fixed template information.** Subsequent pages are in the same format **(see Attachment #1). Vendor shall assume programming costs associated with printing information in correct location on statement and running column lines.**
3. The electronic file shall be produced by University Physicians produces 2 files on the 7th, 15th, 23rd, and the last day of the month. One file is Weekly Statements, and one is Informational Statements. These files are zipped and

FTP'd to the vendor on the following business day.

4. Presort First Class mailing. (Supplier is responsible to bill us for postage).

5. Vendor shall guarantee a forty-eight (48) hour turn-around time for printing and mailing the statements.

6. "BAR CODING" (end-of-collation mark) shall be programmed by vendor, as well as automatically matching and nesting multiple pages through the used of intelligent inserting equipment. Vendor assumes programming cost.

7. **Vendor shall sort statements by "ACCOUNT STATUS" indicator field on file within each patient account. Vendor shall assume programming costs.** Sorting is necessary to accommodate specific mailing instructions **(see Attachment #2) entitled "Statement Instructions."**

8. Vendor to fax, e-mail, or transmit in some other form, a random sample of printed Statements (weekly and information) to University Physicians prior to run for approval. **NO STATEMENTS shall be run without a sample being reviewed and approved by a University Physicians representative.**

UCONN HEALTH

Amount Due	Payment Due By
$280.00	06/06/19

Hi, [redacted]

Thank you for choosing UConn Health.

Guarantor # [redacted] **Patient:** [redacted] **MRN:** [redacted]

Charges	**3,612.59**
Previous Services	3,612.59
New Services	0.00
Payments/Adjustments	**-3,332.59**
Insurance Payments/Adjustments	-3,332.59
Patient Payments/Adjustments	0.00
Total Balance	**280.00**

Amount Due
$280.00

Customer Service

Call 860-679-6387 8:00am to 4:30pm, Monday through Friday, to:

* Pay by phone
* Inquire about our interest free financing and low monthly payment plans
* Learn about Financial Assistance for eligible individuals

Pay Securely Online

Login to your myUConnHealth account to pay online!
https://myuconnhealth.uconn.edu/mychart/

Detach the bottom portion and return with your payment.

UCONN HEALTH

☐ MasterCard	☐ Discover	☐ Visa
Cardholder		
Card #	Exp Date	Sec Code
Signature		

Date: May 09, 2019 Guarantor: [redacted]
You owe: $280.00 Due by: June 06, 2019

UCONN HEALTH

Amount Due	Payment Due By
$280.00	06/06/19

Accounts on Previous Statements

Physician Services for Girard, Eric D, MD in OPPV GENERAL SURGERY

Acct #[redacted]

January 18, 2019

Date	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Patient Balance
Jan 18, 2019	OFFICE OUTPATIENT VISIT 40 MINUTES	275.00			
Jan 30, 2019	ANTHEM INSURANCE PAYMENT		-150.18		
Jan 30, 2019	ANTHEM CONTRACTUAL WRITE-OFF		-109.82		
	Your Responsibility				**$15.00**

Physician Services for Girard, Eric D, MD in OPPV GENERAL SURGERY

Acct #[redacted]

February 05, 2019

Date	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Patient Balance
Feb 05, 2019	OFFICE OUTPATIENT VISIT 15 MINUTES	140.00			
Feb 13, 2019	ANTHEM INSURANCE PAYMENT		-68.19		
Feb 13, 2019	ANTHEM CONTRACTUAL WRITE-OFF		-56.81		
	Your Responsibility				**$15.00**

Visit to UConn Health Department of Emergency Services

Acct #[redacted]

March 28, 2019

Date	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Patient Balance
	PHARMACY-GENERAL	24.00			
	IV THERAPY-GENERAL	937.00			
	MEDICAL/SURGICAL SUPPLIES AND DEVICES-GENERAL	9.00			
	LABORATORY-GENERAL	716.00			
	EMERGENCY ROOM-GENERAL	1,043.00			
	PHARMACY-EXTENSION OF 025X-ERYTHROPOIETIN (EPO) <10,000 UNITS	5.59			
	PROFESSIONAL FEES (EXTENSION OF 096X AND 097X)-EMERGENCY ROOM	463.00			
Apr 10, 2019	ANTHEM INSURANCE PAYMENT Copay: 250.00		-1,911.22		
Apr 10, 2019	ANTHEM CONTRACTUAL WRITE-OFF		-1,036.37		
	Your Responsibility				**$250.00**

Guarantor #[redacted]

UCONN | SCHOOL OF DENTAL MEDICINE

263 FARMINGTON AVENUE
FARMINGTON CT 06030-2105

Billing Inquiries: (860) 679-2464
Oral Surgery Billing Only: (860) 679-4005
Orthodontic Billing Only: (860) 679-3439

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☐ VISA	☐ MASTERCARD	☐ DISCOVER
CARD NUMBER:		EXPIRATION DATE:
SIGNATURE:		3 DIGIT CODE ON BACK OF CARD:

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT #
02/14/2019	$140.00	1810 5202 5202

SHOW AMOUNT PAID HERE:

MAKE CHECKS PAYABLE/REMIT TO:

UCONN SCHOOL OF DENTAL MEDICINE
263 FARMINGTON AVENUE
FARMINGTON CT 06030-2105

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

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

DATE	LOCATION	PROC CODE	TOOTH# SURF	PROCEDURE DESCRIPTION	INSURANCE PENDING	PATIENT RESPONSIBILITY
Account # 181				**Patient Nam**		
01/01/2019				Opening Balance	$28.00	$28.00
02/07/2019	PEDKAN	D2930	I	Prefab SS crown - prim. tooth	$167.00	$0.00
02/07/2019	PEDKAN	D2930	K	Prefab SS crown - prim. tooth	$167.00	$0.00
02/07/2019	PEDKAN	D7140	D	Extraction erupted tooth or exposed root	$100.00	$0.00
02/07/2019	PEDKAN	D7140	E	Extraction erupted tooth or exposed root	$100.00	$0.00
02/07/2019	PEDKAN	D7140	F	Extraction erupted tooth or exposed root	$100.00	$0.00
02/07/2019	PEDKAN	D7140	G	Extraction erupted tooth or exposed root	$100.00	$0.00
02/07/2019	PEDKAN	D0120		Periodic oral evaluation	$45.00	$0.00
02/07/2019	PEDKAN	D0210		Intraoral-complete series	$128.00	$0.00
02/07/2019	PEDKAN	D1120		Prophy - child	$38.00	$0.00
02/07/2019	PEDKAN	D1206		Topical fluoride varnish	$28.00	$0.00
02/07/2019	PEDKAN	D2391	T O	Resin-based comp-1 surf post.	$110.00	$0.00
02/07/2019	PEDKAN	D2392	J CL	Resin-based comp-2 surf post.	$132.00	$0.00
02/07/2019	PEDKAN	D2930	A	Prefab SS crown - prim. tooth	$167.00	$0.00
02/07/2019	PEDKAN	D2930	B	Prefab SS crown - prim. tooth	$167.00	$0.00
02/07/2019	PEDKAN	D3220	A	Therapeutic pulpotomy	$117.00	$0.00
02/07/2019	PEDKAN	D3220	B	Therapeutic pulpotomy	$117.00	$0.00
02/07/2019	PEDKAN	D7140	S	Extraction erupted tooth or exposed root	$100.00	$0.00
02/07/2019	PEDKAN	D7140	L	Extraction erupted tooth or exposed root	$100.00	$0.00
Account # 5202				**Patient Name:**		
01/01/2019				Opening Balance	$28.00	$28.00
Account # 520.				**Patient Name**		

Payment for your balance is one hundred twenty days overdue.

ABOUT YOUR STATEMENT

- Allow 10 business days for your statement to reflect your payment.
- Refer to past statements for previous detail.

PAY AMOUNT DUE	$140.00
ON OR BEFORE	03/16/2019

	CURRENT BALANCE	BAL. OVER 30 DAYS	BAL. OVER 60 DAYS	BAL. OVER 90 DAYS	BAL. OVER 120 DAYS	PAYMENTS RECEIVED AFTER STATEMENT CLOSING DATE ARE NOT REFLECTED ON THIS STATEMENT
PENDING INSURANCE	$1,983.00	$0.00	$0.00	$0.00	$0.00	
PATIENT RESPONSIBILITY	$0.00	$0.00	$0.00	$0.00	$140.00	STATEMENT CLOSING DATE:02/14/2019

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IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

Your Name (Last, First, Middle Initial)		Date of Birth
Address		
City	State	Zip
Telephone ( )		
Social Security #		
Employer's Name		Telephone ( )
Employer's Address		
City	State	Zip
Please Indicate If Applicable: ☐ AUTO ACCIDENT ☐ WORKER'S COMPENSATION		Date of Injury

Your PRIMARY Insurance Company's Name		
Primary Insurance Company's Address		
City	State	Zip
Policyholder's ID Number		Group Plan Number
Your SECONDARY Insurance Company's Name		
Secondary Insurance Company's Name		
Secondary Insurance Company's Address		
City	State	Zip
Policyholder's ID Number		Group Plan Number

"DETACH HERE AND RETURN ABOVE STUB"

FOR HOSPITAL OR OTHER FACILITY PATIENTS

YOU COULD RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED

TOTAL DIAGNOSTIC OR TREATMENT COSTS

PHYSICIAN OR PROVIDER'S FEE	HOSPITAL CHARGES OR OTHER FACILITY

This statement is not a duplicate charge, but a separation of the facility and physician or provider's fee. These services were provided while you were under our care, or at the request of your other physicians or providers.

[redacted] a separate charge for use of its equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in a hospital or other facility.

If you have any questions concerning your bill, please call our office and we will be happy to assist you.

IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE PHONE NUMBER ON THE REVERSE SIDE.

UCONN | SCHOOL OF DENTAL MEDICINE

263 FARMINGTON AVENUE
FARMINGTON CT 06030-2105

Billing Inquiries: (860) 679-2464
Oral Surgery Billing Only: (860) 679-4005
Orthodontic Billing Only: (860) 679-3439

[redacted]

☐ VISA	☐ MASTERCARD	☐ DISCOVER
CARD NUMBER:		EXPIRATION DATE:
SIGNATURE:		3 DIGIT CODE ON BACK OF CARD:

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT #
02/14/2019	$140.00	181[illegible] 5202 52029[illegible]
SHOW AMOUNT PAID HERE:		

MAKE CHECKS PAYABLE/REMIT TO:

UCONN SCHOOL OF DENTAL MEDICINE
263 FARMINGTON AVENUE
FARMINGTON CT 06030-2105

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

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

DATE	LOCATION	PROC CODE	TOOTH# SURF	PROCEDURE DESCRIPTION	INSURANCE PENDING	PATIENT RESPONSIBILITY
01/01/2019				Opening Balance	$28.00	$28.00
01/03/2019	PEDKAN			Insurance Check #40958034 amt. $38.00 DOS 09-06-2018	$28.00	0.00
01/03/2019	PEDKAN			Transfer Balance to Patient DOS 09-06-2018	$28.00	$56.00
01/03/2019	PEDKAN			Transfer Balance to Patient DOS 09-06-2018	$28.00	$27.00

Payment for your balance is one hundred twenty days overdue.

ABOUT YOUR STATEMENT

- Allow 10 business days for your statement to reflect your payment.
- Refer to past statements for previous detail.

PAY AMOUNT DUE	$140.00
ON OR BEFORE	03/16/2019

	CURRENT BALANCE	BAL. OVER 30 DAYS	BAL. OVER 60 DAYS	BAL. OVER 90 DAYS	BAL. OVER 120 DAYS	PAYMENTS RECEIVED AFTER STATEMENT CLOSING DATE ARE NOT REFLECTED ON THIS STATEMENT
PENDING INSURANCE	$1,983.00	$0.00	$0.00	$0.00	$0.00	
PATIENT RESPONSIBILITY	$0.00	$0.00	$0.00	$0.00	$140.00	STATEMENT CLOSING DATE:02/14/2019

91254-81-4

IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

Your Name (Last, First, Middle Initial)		Date of Birth
Address		
City	State	Zip
Telephone ( )		
Social Security #		
Employer's Name		Telephone ( )
Employer's Address		
City	State	Zip
Please Indicate if Applicable: ☐ AUTO ACCIDENT ☐ WORKER'S COMPENSATION		Date of Injury

Your **PRIMARY** Insurance Company's Name		
Primary Insurance Company's Address		
City	State	Zip
Policyholder's ID Number		Group Plan Number
Your **SECONDARY** Insurance Company's Name		
Secondary Insurance Company's Name		
Secondary Insurance Company's Address		
City	State	Zip
Policyholder's ID Number		Group Plan Number

"DETACH HERE AND RETURN ABOVE STUB"

FOR HOSPITAL OR OTHER FACILITY PATIENTS

YOU COULD RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED

TOTAL DIAGNOSTIC OR TREATMENT COSTS

PHYSICIAN OR PROVIDER'S FEE	HOSPITAL CHARGES OR OTHER FACILITY

This statement is not a duplicate charge, but a separation of the facility and physician or provider's fee.
These services were provided while you were under our care, or at the request of your other physicians or providers.

[redacted] may include a separate charge [redacted] equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in a hospital or other facility.

If you have any questions concerning your bill, please call our office and we will be happy to assist you.

IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE PHONE NUMBER ON THE REVERSE SIDE.

UCONN | SCHOOL OF DENTAL MEDICINE

UNIVERSITY DENTISTS
263 FARMINGTON AVENUE
FARMINGTON CT 06030-2105

Billing Inquiries: (860) 679-2464
Oral Surgery Billing Only: (860) 679-4005
Orthodontic Billing Only: (860) 679-3439
Storrs Office Billing Only: (860) 487-9333

☐ VISA	☐ MASTERCARD	☐ DISCOVER
CARD NUMBER:		EXPIRATION DATE:
SIGNATURE:		3 DIGIT CODE ON BACK OF CARD:

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT #
02/14/2019	$260.00	1223 [redacted]

SHOW AMOUNT PAID HERE:

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H004 000002

MAKE CHECKS PAYABLE/REMIT TO:

UNIVERSITY DENTISTS
263 FARMINGTON AVENUE
FARMINGTON CT 06030-2105

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

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

DATE	LOCATION	PROC CODE	TOOTH# SURF	PROCEDURE DESCRIPTION	INSURANCE PENDING	PATIENT RESPONSIBILITY
Account # 1223[redacted]				**Patient Name:**		
01/01/2019				Opening Balance	$0.00	$0.00
01/08/2019	UDPER	D0120		Periodic oral evaluation	$0.00	$95.00
01/08/2019	UDPER	D4910		Perio maintenance	$0.00	$165.00

Payment for your balance is thirty days overdue.

ABOUT YOUR STATEMENT

- Allow 10 business days for your statement to reflect your payment.
- Refer to past statements for previous detail.

PAY AMOUNT DUE	$260.00
ON OR BEFORE	03/16/2019

	CURRENT BALANCE	BAL. OVER 30 DAYS	BAL. OVER 60 DAYS	BAL. OVER 90 DAYS	BAL. OVER 120 DAYS	PAYMENTS RECEIVED AFTER STATEMENT CLOSING DATE ARE NOT REFLECTED ON THIS STATEMENT
PENDING INSURANCE	$0.00	$0.00	$0.00	$0.00	$0.00	
PATIENT RESPONSIBILITY	$0.00	$260.00	$0.00	$0.00	$0.00	STATEMENT CLOSING DATE:02/14/2019

91202-D1-2

IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

Your Name (Last, First, Middle Initial)	Date of Birth
Address	
City / State / Zip	
Telephone ( )	
Social Security #	
Employer's Name	Telephone ( )
Employer's Address	
City / State / Zip	
Please Indicate If Applicable: ☐ AUTO ACCIDENT ☐ WORKER'S COMPENSATION	Date of Injury

Your PRIMARY Insurance Company's Name	
Primary Insurance Company's Address	
City / State / Zip	
Policyholder's ID Number	Group Plan Number
Your SECONDARY Insurance Company's Name	
Secondary Insurance Company's Name	
Secondary Insurance Company's Address	
City / State / Zip	
Policyholder's ID Number	Group Plan Number

"DETACH HERE AND RETURN ABOVE STUB"

FOR HOSPITAL OR OTHER FACILITY PATIENTS

YOU COULD RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED

TOTAL DIAGNOSTIC OR TREATMENT COSTS

- **PHYSICIAN OR PROVIDER'S FEE**
- **HOSPITAL CHARGES OR OTHER FACILITY**

This statement is not a duplicate charge, but a separation of the facility and physician or provider's fee. These services were provided while you were under our care, or at the request of your other physicians or providers.

Your bill from the facility may include a separate charge for use of its equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in a hospital or other facility.

If you have any questions concerning your bill, please call our office and we will be happy to assist you.

IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE PHONE NUMBER ON THE REVERSE SIDE.