

# Physician Statement – side 1



Professional Services Operations  
 Physician Billing  
 File 74432 PO Box 60000  
 San Francisco, CA 94160-0001  
 www.stanfordhospital.com

TAX ID: 77-0465765

1V00001 9999999

9999999  
 SAMPLE A SAMPLE  
 123 S MAIN ST  
 ANYTOWN USA 12345-1234



## Account Summary

<b>A</b> Account Number	9999999	<b>E</b>
Patient Payments (Last 30 Days)	\$ 0.00	
Total Account Balance	\$ 560.46	<b>B</b>
Charges Pending With Insurance	\$ 218.00	
<b>Amount Due</b>	<b>\$ 342.46</b>	

## Insurance Information

Please confirm that information is correct.

**PRIMARY**  
 Insurance MEDICARE ASSIGNED 301  
 Address \_\_\_\_\_  
 City/State/ZIP \_\_\_\_\_  
 Group/Plan \_\_\_\_\_

Our records show that you have one insurance plan.  
 If you are covered by any other insurance plans, please contact a patient account representative.

### A New Billing Statement for You!

As a result of suggestions made to us by patients just like you, we have re-designed our statement to provide you with complete, easy-to-read information about your bill. Thank you for your suggestions and your continued support. We are committed to continuing our efforts to improve the quality of service that we provide for you!

**Statement Date**  
 05/28/2004

## Your Physician Statement

Page 1 of 2

### About Your Statement

Thank you for choosing Stanford University Medical Center for your health care needs. This is a statement of your account for services provided by our physicians. Detailed information on each service rendered can be found on the following pages. The balances due for each service are added together to arrive at the total amount due from you.

**Please send payment in full for \$ 342.46 by 06/08/2004.**

If you have any questions, please call us at 1-800-549-3720 or 1-650-498-5850. Our patient account representatives are available from 9:00 am to 12:30 pm & 1:30 pm to 4:00 pm. Monday-Friday, or use our Automated Voice Telephone System which is available 24-hours a day.

**NOTE: This is a statement for physician services ONLY. You may receive a separate bill for hospital services and/or clinic facility fees.**

Key to important information on your statement:

- A** - Account Number
- B** - Amount Due from You
- C** - Date Payment is Due
- D** - Date(s) of Service
- E** - Payment and Credit Activity
- F** - Insurance Information

Please See Reverse Side For Account Detail →



Statement Date: 05/28/2004

Patient Name	Account Number	Date Due
Sample A Sample	9999999	06/08/2004
<b>Amount Due</b>	<b>Amount Enclosed</b>	
<b>\$ 342.46</b>	\$	

MAKE CHECKS PAYABLE TO:

STANFORD MEDICAL CENTER  
 FILE 74432 PO BOX 60000  
 SAN FRANCISCO, CA 94160-0001



Check here if your address or insurance information has changed. Please indicate changes on the back of this page.

**To pay by credit card:** For your convenience, you may pay by Visa, MasterCard, Discover, or American Express. Please indicate your credit card preference, provide the account information, and sign below.



Account No. \_\_\_\_\_

Expiration Date \_\_\_\_\_

Signature X \_\_\_\_\_

# Physician Statement – side 2

Statement Date  
05/28/2004

Account Number  
9999999

## Patient Statement for Sample A Sample

A summary of services, charges, claims and payments is provided below.  
Please keep this page for further reference.

Page 2 of 2

## Summary of Services and Amounts Due

Invoice Number: 99999999  
Provider: Jane Perkins, MD, Nephrology

Service Date: 01/25/2003 **D**  
Location: Inpatient

Your insurance plan has responded with payment, adjustment and/or denial as indicated below. Payment for this balance (and other balances due) can be made by paying the full amount due as shown on the payment stub of this statement.

### Services and Charges

01/25/2003	99232	SUBSEQUENT HOSP. CARE	180.00
01/26/2003	99232	SUBSEQUENT HOSP. CARE	180.00
01/27/2003	90935	HEMODIALYSIS, SINGLE EVAL.	537.00
01/28/2003	90935	HEMODIALYSIS, SINGLE EVAL.	537.00
01/29/2003	90935	HEMODIALYSIS, SINGLE EVAL.	537.00
		<b>Total Charges</b>	<b>\$ 1971.00</b>

### Claims and Payment Activity **E**

04/11/2003	Insurance Claim Filed	
06/13/2003	Insurance Payment	
	Payment	0.00
	Adjustment	0.00
08/28/2003	Insurance Payment	
	Payment	-383.49
	Adjustment	-1227.51
08/28/2003	Insurance Payment	
	Payment	0.00
	Adjustment	0.00
01/14/2004	Medicare Claim Filed	
01/29/2004	Medicare Payment	
	Payment	-17.54
	Note: Applied to Deductible	

Amount Now Due For This Service \$ 342.46

ICD9: 585

Referring Physician: Ronald Smith, MD

You will receive a  
separate  
statement of  
account  
for services  
provided by our  
physicians.

## Change of Patient/Guarantor Information

New Address	City	State	Zip Code	New Phone #
Is this your Primary or Secondary insurance ? (Circle one)				
PRIMARY		SECONDARY		
Policy Holder (as it appears on the insurance card)	Policy/Identification #	Group #	Date of Birth	Coverage Effective Date
Group Name or Policy Holder's Employer/Union		Insurance Company Name		
Insurance Company Claim Address		Insurance Company Phone Number		