Cathedral Hospital

632 Ellsworth Road
Rome, NY 13441

1 PATIENT NAME		
JANE DOE		
2 SERVICE DATE(S) From/Through	3 STATEMENT DATE	PAGE
01/03/04	04/30/04	1

4 THIS IS THE CURRENT INSURANCE INFORMATION ON FILE

Please review and make corrections on the back of this form.

INSURANCE NAME	POLICY NUMBER
1. INSURANCE GROUP 1	123456789
2. INSURANCE GROUP 2	4567890
3.	

5 If paying by CREDIT CARD, please complete this section

Please review and make corrections on the back of this form.

Card # _____

Evp. Date _____ / _____ AMT. AUTHORIZED $ _____

SIGNATURE _____

6 CHECK/M.O.

AMOUNT ENCLOSED

$ _____

7

JANE DOE
1 MAIN ST
ANYTOWN, NY 10003

8

CATHEDRAL HOSPITAL
P.O. BOX 1440
ROME, NY 13442-1440

9 ACCOUNT NUMBER	10 PREVIOUS BALANCE	11 CHARGES	12 EST. INS. COVERAGE	13 PAYMENTS/ADJ'S	14 AMT. DUE FROM PATIENT
0123456789	0	123.00	0	75.00	48.00

15 ACCOUNT NUMBER	16 PATIENT NAME	17 SERVICE DATE(S)	18 STATEMENT DT.	PAGE
0123456789	JANE DOE	01/03/04	04/30/04	1

19 DATE(S)	20 DESCRIPTION	21 CHARGES	22 EST. INS. COVERAGE	23 PAYMENTS/ADJ'S
01/03/04	NEW PATIENT EMERGENCY ROOM	123.00		
02/15/04	INSURANCE GROUP 1 CONTRACT ALLOW			-60.00
02/15/04	INSURANCE GROUP 2 CONTRACT ALLOW			-15.00
	"This bill is for services provided to you on your recent visit to Cathedral Hospital. You may receive additional bills from independent doctors or laboratories who were involved with your care during your visit."			
24 PREVIOUS BALANCE	COLUMN TOTALS			
	25 AMOUNT DUE FROM PATIENT			48.00

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

For questions about this statement, please call:
(123) 456-7890 M-F 9:00 a.m. to 4:00 p.m. central

SEE REVERSE SIDE FOR EXPLANATION OF STATEMENT AND IMPORTANT INFORMATION ON YOUR PATIENT RIGHTS.

To make corrections or updates to your insurance information, please use the space below. Please include a copy of your insurance card.

Insurance #_____
Insurance company name: _____
Address: _____
City/State/Zip: _____
Policy no.: _____
Relationship to patient: _____
Employer name: _____

Insurance 2 #_____
Insurance company name: _____
Address: _____
City/State/Zip: _____
Policy no.: _____
Relationship to patient: _____
Employer name: _____

For questions, please contact our billing department M-F 9:00 a.m. to 4:00 p.m. at (123) 456-7890.

FORM FIELD KEY

Item #	Item description
1 & 16:	Patient Name or person who received services.
2& 17	Service Date(s): Period of time in which services were provided.
3 & 18:	Statement date: Date on which this form was produced.
4:	Insurance information on file which includes insurance name and policy numbers.
5:	If paying by credit card, please include all information: a. Credit Card number b. Expiration date c. Amount Authorized for payment d. Signature of cardholder
6:	Check/ M.O.: Enter amount being paid by check or money order.
7:	Responsible party: Name/mailing address of the person responsible for payment.

Item #	Item description
8:	Payment mailing address: Be sure that this address is visible in the window envelope when making your payment by mail.
9&15:	Account Number: Number used to identify the account.
10&24:	Previous Balance: Amount owed on this account as of the last statement.
11&21:	Charges: Charges incurred on the account since the last statement.
12&22:	Estimated insurance coverage: Amount of payment expected from insurance carrier(s), but not yet received.
13&23:	Payments/Adjustments: Total of payments by insurance and/or responsible party and adjustments (such as credits) made to the account since the last statement.
14&25:	Amount Due from Patient: Amount currently due from the patient/responsible party.