

Summary of Hospital Services and Charges

Account Number: 1234567

Date	Description	Amount	Date	Description	Amount
092004	MRI L-SPINE W/O CONTRAST	\$394.00			
101904	MEDICARE PAYMENT	\$-59.87			
101904	MEDICARE ADJUSTMENT	\$-319.16			
092004	BONE IMAGING, WHOLE BODY	\$229.00			
101904	MEDICARE PAYMENT	\$-35.02			
101904	MEDICARE ADJUSTMENT	\$-185.22			
		Total Amount Due		\$23.73	

If you require an itemized statement, please call: 555-555-5555

* * * * PLEASE SEE LETTER ON REVERSE SIDE * * * *

If we do not have insurance information please fill out information below.

Patient Name _____ Date of Birth _____ SS# _____ Marital Status S M D W

Street _____ Home Phone _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Employer Address _____

Insurance Company _____ Ins. Company Address _____

Subscriber/Cardholder Name _____ Relationship to Subscriber Self Spouse
Dependent Other _____

Identification No. _____ Group No. _____

Job connected illness or injury? Yes No Auto Accident? Yes No Date of Onset or Accident: ____ / ____ / ____

Other Insurance Information _____

* If remitting payment, please make sure address on other side appears through window *