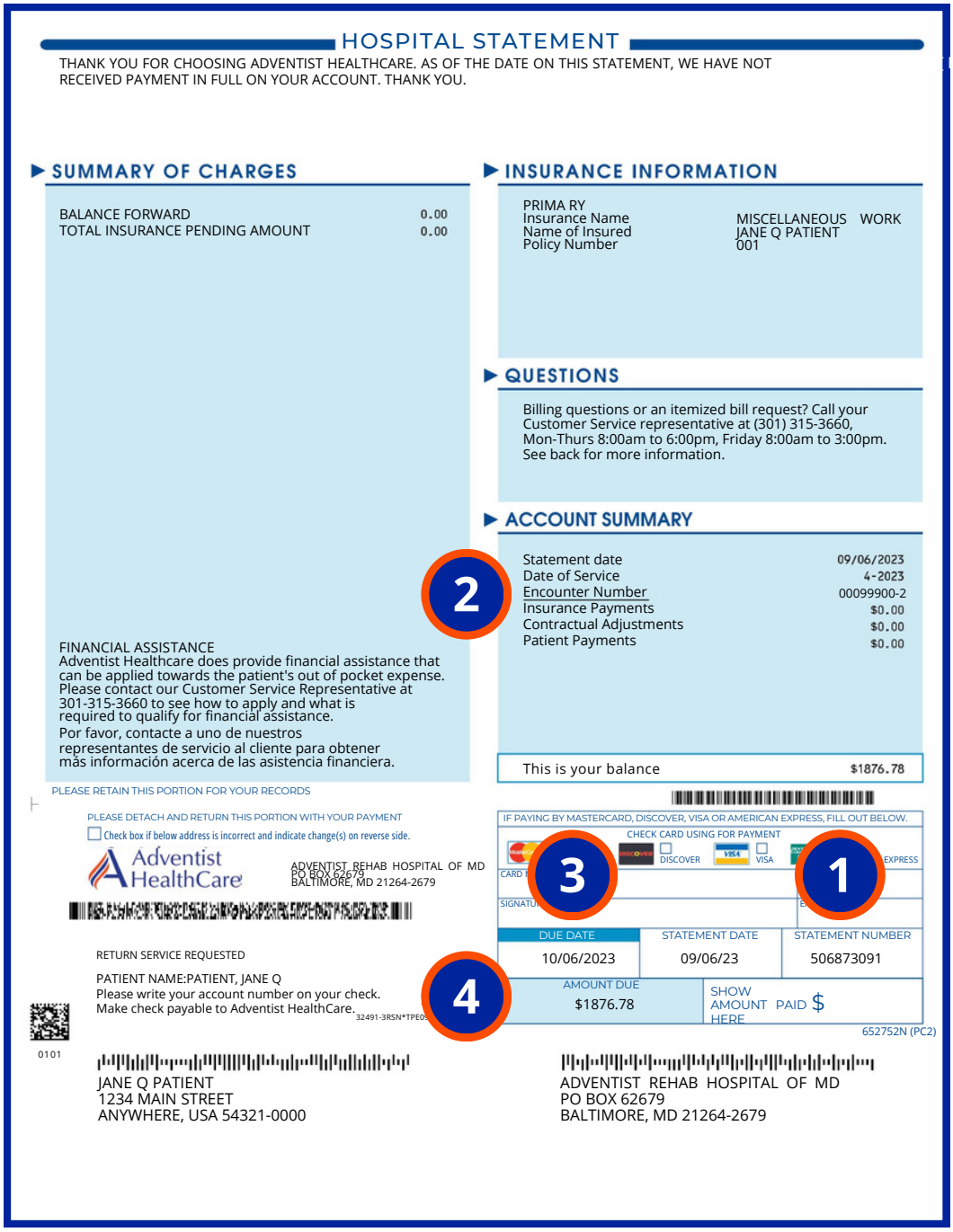
Adventist HealthCare

# Sample Billing Statement

## Rehabilitation



HOSPITAL STATEMENT

THANK YOU FOR CHOOSING ADVENTIST HEALTHCARE. AS OF THE DATE ON THIS STATEMENT, WE HAVE NOT RECEIVED PAYMENT IN FULL ON YOUR ACCOUNT. THANK YOU.

▶ SUMMARY OF CHARGES

| | |
|---|---|
| BALANCE FORWARD | 0.00 |
| TOTAL INSURANCE PENDING AMOUNT | 0.00 |

FINANCIAL ASSISTANCE
Adventist Healthcare does provide financial assistance that can be applied towards the patient's out of pocket expense. Please contact our Customer Service Representative at 301-315-3660 to see how to apply and what is required to qualify for financial assistance.
Por favor, contacte a uno de nuestros representantes de servicio al cliente para obtener más información acerca de las asistencia financiera.

▶ INSURANCE INFORMATION

| | |
|---|---|
| PRIMA RY | |
| Insurance Name | MISCELLANEOUS WORK |
| Name of Insured | JANE Q PATIENT |
| Policy Number | 001 |

▶ QUESTIONS

Billing questions or an itemized bill request? Call your Customer Service representative at (301) 315-3660, Mon-Thurs 8:00am to 6:00pm, Friday 8:00am to 3:00pm. See back for more information.

▶ ACCOUNT SUMMARY

| | |
|---|---|
| Statement date | 09/06/2023 |
| Date of Service | 4-2023 |
| Encounter Number | 00099900-2 |
| Insurance Payments | $0.00 |
| Contractual Adjustments | $0.00 |
| Patient Payments | $0.00 |

This is your balance $1876.78

PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

Check box if below address is incorrect and indicate change(s) on reverse side.

Adventist HealthCare

ADVENTIST REHAB HOSPITAL OF MD
PO BOX 62679
BALTIMORE, MD 21264-2679

RETURN SERVICE REQUESTED

PATIENT NAME:PATIENT, JANE Q
Please write your account number on your check.
Make check payable to Adventist HealthCare.

32491-3RSN*TPE0

0101

JANE Q PATIENT
1234 MAIN STREET
ANYWHERE, USA 54321-0000

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

DISCOVER VISA EXPRESS

CARD

SIGNATURE

| DUE DATE | STATEMENT DATE | STATEMENT NUMBER |
|---|---|---|
| 10/06/2023 | 09/06/23 | 506873091 |

| AMOUNT DUE | |
|---|---|
| $1876.78 | SHOW AMOUNT PAID HERE $ |

652752N (PC2)

ADVENTIST REHAB HOSPITAL OF MD
PO BOX 62679
BALTIMORE, MD 21264-2679

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3

1

4

## Help!

Use this visual guide to find information on your billing statement.

1. **Statement Number**
2. **Encounter Number**
3. **Due Date**
4. **Amount Due**