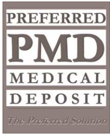
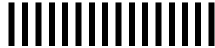
Date of Service: 10/01/2009 PC#: 8675309





PMD - Payment Processing Center
10604 Justin Dr. Des Moines, IA 50322

A Message from your Healthcare Provider

Thank you for choosing Mercy Medical Center for your healthcare needs.

Preferred Medical Deposit (PMD) is an extension of the business office for Mercy Medical Center and has been contracted to manage the patient responsibility portion of your bill.

PMD is not a collection agency and your account is not in default.

Payment in full is expected upon receipt unless other acceptable arrangements are made.

If you would like to apply for financial assistance, please call our customer service number.

John Smith
123 Anylane
Anytown, IA 55555-1234

- Please note: This balance may not reflect the entire balance due from all accounts with Mercy Medical Center. Any payments received will be posted to the oldest date of service.

Account Summary

Statement Date:	1/1/2010
Account Number:	**008675309MC**
Patient Name:	HAPPY PATIENT
Date of Service:	10/01/2009
Type of Service:	Diagnostic Imaging
Facility:	Mercy North
Total Charges:	$5,000.00
1st Insurance Payments/ Adjustments:	$3,000.00
2nd Insurance Payments/Adjustments:	$1,000.00
Patient Payments:	$50.00
Other Adjustments:	$100.00
Please Pay by 01/20/2010:	**$850.00**

Customer Service Information

Hours of Operation
Monday - Friday 8:00 a.m. - 8:00 p.m.
Saturday 9:00 a.m. - 1:00 p.m.
Phone: 515-276-8645 **Toll Free: 1-800-777-8645**
http://www.paymentcenteronline.com
E-mail: inquiry@pmdinc.cc

Insurance Information

If the information below is not correct please indicate changes on the reverse side.

Primary Insurance Policy Number	**ABC Insurance Ltd.** **987458254**
Secondary Insurance Policy Number	**XYZ Insurance LLC** **476957058**

PLEASE RETURN THIS PORTION WITH PAYMENT

☐

☐

Card #: ____________________________ CV2 #: __________

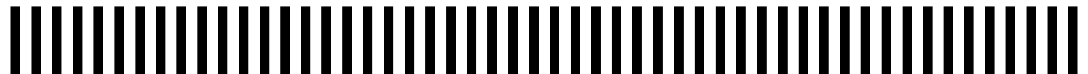
Signature: __________________________ Exp Date: ___ /___

Print Name: _________________________ Amount: $_______

Patient Name: Happy Patient
Account #: 008675309MC
PC #: 8675309
Due Date: 01/20/2010
Amount Due: $850.00

Amount Enclosed ___________

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



Mercy Medical Center
Payment Processing Center—PMD
PO Box 219714
Des Moines, IA 64121-9714

How we Handle Your Account

Health Insurance Billing:
Your Healthcare Provider has billed all of your health insurance carriers if you submitted all the necessary information. You are responsible for any portion of your charges remaining unpaid by your insurance.
If you feel your insurance company should have paid your bill, please contact your insurance company. It is important for you to be aware that you are responsible for any exclusions, co-payments and deductibles outlined in your insurance plan.
When another provider is involved with your care, their charges are billed separately and are not included in your hospital bill. Other providers include, but not limited to: ER Physicians, Anesthesiologists, Radiologists and Pathologists.

Payment Options

Your Healthcare Provider is committed to working with you to resolve your balance. Please review the following payment options to help you satisfy your obligation as quickly as possible.

www.
PaymentCenterOnline
.com

PMD's Payment Center Online gives you greater access to your information 24 hours a day.

- Make online payments
- Update or review your personal information
- View payment history

http://www.paymentcenteronline.com

Payment in full:
Payment can be made by check, money order, or credit card (please see other side for credit cards that are accepted).

Payment arrangements:
A payment plan can be set up in accordance with your provider's credit policy. Please contact our Payment Center to set up a payment plan.

Federal or State programs:
For patients who do not have health insurance, your Healthcare provider will assist you in determining eligibility for federal or state programs; such as Medicare or Medicaid. Please contact a Payment Center Representative for more information.

Other payment sources:
If the treatment you received was a direct result of any of the following circumstances, you may be eligible for assistance from other sources: *auto accident, accident on property, assault, or injured while working.* You may also have other options if you recently lost a job.

Financial Assistance:
If you feel you are unable to pay all or part of your bill, you may qualify for financial assistance. A Healthcare Assistance Program is available to assist qualifying patients to aid in the financial resolution of their hospital bills. Each situation will be reviewed for special circumstances based on good faith efforts and other factors.

When you provide a check as payment, you authorize us to use information from your check to make a one-time electronic fund transfer (EFT) from your account, in which case funds may be withdrawn from your account as soon as the same day we receive your payments, and you will not receive your check back from your financial institution. If you prefer not to have your check converted to an EFT, you can opt out by calling 1-800-777-8645.

COMPLETE FOR CHANGE OF ADDRESS

ADDRESS ______________________________ PHONE NUMBER (HOME) (_____)_______________

CITY __________________________ STATE _____ PHONE NUMBER (WORK) (_____)_______________

ZIP CODE ____________ --- __________

INSURANCE INFORMATION (Please sign and date below)

INSURANCE COMPANY NAME ______________________________ EMPLOYER ____________________

CLAIMS ADDRESS ______________________________________ CITY ____________

STATE __________ ZIP CODE ____________ --- _______ BENEFITS PHONE NUMBER (____)____________

SUBSCRIBER NAME ______________________________ SUBSCRIBER DOB ______________

PATIENT NAME______________________________ PATIENT DOB____________________

POLICY/ID# ____________________________ GROUP# ______________ PAYER ID ____________

I authorize the hospital to submit any/or all medical data to my insurance company, and authorize the assignment of any benefits or payments to the hospital. I understand I am financially responsible to the hospital for charges not covered by this authorization.

Signed ______________________________________ Date ______________________