

### Back of Statement

- M** Date of service
- N** Medical facility or practice location
- O** Description of service
- P** Charge per service
- Q** Insurance payment or adjustments per service
- R** Payments per service
- S** Balance due per service

Date of Service	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Patient Balance
<b>Non-Payment Plan Account Detail</b>					
VISIT NUMBER 00000000 Medical facility or practice location <b>N</b>					
00/00/00	DESCRIPTION OF SERVICE Total Guarantor Adjustments	<b>P</b> 0.00		<b>R</b> -0.00	<b>0.00</b>
<b>M</b>	<b>O</b> <b>Balance</b>				
VISIT NUMBER 00000000 Medical facility or practice location					
00/00/00	DESCRIPTION OF SERVICE	0.00			<b>0.00</b>
	<b>Balance</b>				
VISIT NUMBER 00000000 Medical facility or practice location					
00/00/00	DESCRIPTION OF SERVICE	<b>P</b> 0.00	<b>Q</b> -0.00		<b>S</b> <b>0.00</b>
	Total Insurance Adjustments		-0.00		
	Total Insurance Payments		-0.00		
	<b>Balance</b>				

Customer Balance	0.00
Payment Plan Balance	
Payment Plan Amount Due	
<b>Pay This Amount</b>	<b>0.00</b>

### Questions?

Call our Patient Accounts Customer Service Team toll-free at (866) 814-7275 or locally at (269) 428-5007.

Our business hours are:  
 Monday – Friday  
 8:00 a.m. to 5:00 p.m.

[www.lakelandhealth.org](http://www.lakelandhealth.org)

## Your New Billing Statement



NS021-79 (2/12)

## Explanation of Your New Billing Statement

In our efforts to improve service to you, Lakeland HealthCare has redesigned our billing statement to make it easier for you to read and understand. Patients with multiple Lakeland bills will benefit from our new consolidated single-billing statement. Most physician, lab, and hospital bills will be rolled into one statement with one due date for one payment.

This brochure will show you a sample of our new billing statement and guide you through the various sections.


### Questions?

Your input is valuable as we continue to make improvements to our billing system. If you have comments or questions about your new Lakeland HealthCare billing statement, please call our Patient Accounts Customer Service Team toll-free at (866) 814-7275 or locally at (269) 428-5007.

Our business hours are:  
Monday – Friday  
8:00 a.m. to 5:00 p.m.

[www.lakelandhealth.org](http://www.lakelandhealth.org)

Lakeland Hospital  
PO Box 441575  
Detroit MI 48244-1575

 **Lakeland HealthCare**  
Medical Excellence. Compassionate Care.

**Summarized Statement of Your Lakeland HealthCare Balance**

**A Responsible Party**  
10000 Street Rd  
City, State Zip

**News Update: B**  
You are looking at your new Lakeland HealthCare monthly statement. It has been redesigned to gather all your Lakeland Medical Practices billing accounts in one comprehensive statement.

**Questions?**  
If you have any questions or concerns with your bill please call our customer service representatives. A representative will be happy to assist you.  
If you are unable to pay the balance in full, we do offer monthly payment options and financial assistance programs to those who qualify.

**Customer Service Contact: C**  
(269) 428-5007 or (866) 814-7275  
Monday to Friday 8:00 a.m. to 5:00 p.m.

**Account Summary**

Date: 00/00/00	Payment Due Date: 00/00/00 <b>F</b>			
Patient Name: <b>D</b>	Amount Due: <b>G</b>			
Customer Number: <b>E</b>	Balance: <b>H</b>			
	0-30 Days	31-60 Days	61-90 Days	Over 90 Days
Customer Balance	0.00	0.00	0.00	0.00

**Payment Information**

Listed above is your current balance and the due date for your payment. We offer many convenient ways for you to pay your bill:

- I By phone:** (269) 428-5007 or (866) 814-7275 Monday to Friday 8:00 a.m. To 5:00 p.m.
- By mail:** return the below statement portion with check or money order payable to Lakeland Hospital.




--- Please detach bottom portion and send in with your payment. ---

---

Make your check or money order payable to:  
Lakeland Hospital.

Please check this box if address or insurance information is incorrect. Indicate changes on the reverse side.

**If paying by Mastercard, Visa, or Discover fill out below:**

<input type="checkbox"/> 	<input type="checkbox"/> 	<input type="checkbox"/> 
Card Number:	CW Code:	Amount:
Signature	Exp. Date:	

Due Date 00/00/00	Pay this Amount <b>K</b> 0.00	Customer # 0000000
----------------------	----------------------------------	-----------------------

Guarantor: Responsible Party  
Invoice: 0000000

**L** Lakeland Healthcare  
Dept #771508  
PO Box 77000  
Detroit MI 48277-1508

## Front of Statement

- A** Name and address of responsible party
- B** News update/important information
- C** How to contact us with questions
- D** Patient's name
- E** Customer number
- F** Payment due date
- G** Amount due
- H** Account balance
- I** Payment options – mail or phone
- J** Information needed for paying by credit card
- K** Amount due with this statement
- L** Address to mail payments (check, money order, or credit card information)