

Important Message

Thank you for choosing Yale New Haven Hospital as your healthcare provider. This is an attempt to collect a debt. Any information will be used for that purpose.

Please pay upon receipt of this statement.

HOS10M.A45VWV000567.J0BYN4.000001 000001

SAMPLE A SAMPLE
123 MAIN STREET
NORTH HAVEN CT 06473



Account Summary

Patient Name	SAMPLE ASAMPLE
Account Number	0010234560007
Statement Date	08/07/12
Service Dates	07/03/12 through 07/03/12
Total Charges	\$513.17
Patient Payments/Adjustments	\$0.00
Insurance Payments/Adjustments	-\$483.53
Amount Now Due	\$29.64

Insurance Information

Insurance 1 - UNITED HLTHCARE-MEDICARE
Insurance 2 -
Insurance 3 -

{If there are updates to your insurance, please fill out the insurance change form on the back or call (203)789-3227.}

Contact Us

Billing questions?
Phone: (203)789-3227, (203)789-3430, (203)789-3234,
or (203)789-3578
8:30 am - 4:30 pm, Monday - Friday

Patient Services Provided

Please see the following pages for a Summary of Charges.

Detailed Itemization of Charges available on request.







Online Billing Manager, 24 hours per day, 7 day per week. www.ynhh.org. A simple and easy way to access your updated account information and pay your accounts online.

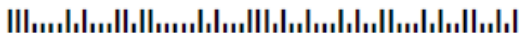


- Make Check Payable to Yale New Haven Hospital.
- Please include your Phone Number on your check.
- Enclose this payment stub with your payment.

Amount Paid
\$

PATIENT NAME	ACCOUNT NUMBER	AMOUNT YOU OWE	METHOD OF PAYMENT
SAMPLE A SAMPLE	0010234560007	\$29.64	Check One: <input type="checkbox"/> Payment Enclosed <input type="checkbox"/> Charge <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  Credit Card Number _____ Exp. Date _____ Credit Card Expiration Date _____ 3Digit Security Code (on back) _____ Credit Card Holder's Signature _____ (Cannot be processed without Signature)

YALE NEW HAVEN HOSPITAL
PO BOX 416308
BOSTON, MA 02241-6308



Summary of Charges

Diagnostic Mammography

TOTAL CHARGES:
Charges

\$513.17

\$513.17
For Your Information
Responsibility For Payment

Even though you may have insurance, you as guarantor or patient are primarily responsible for payment of this bill and will receive a statement. Yale New Haven Hospital will bill your insurance company if you have furnished us with the proper information. However, THE HOSPITAL WILL NOT ACCEPT RESPONSIBILITY FOR COLLECTING YOUR INSURANCE CLAIM or negotiating a settlement on a disputed claim.

Financial Assistance Program

If you are not able to pay for all or part of your bill, please contact the Patient Accounts Dept. at (203)789-3227 between 8:30 am and 4:30 pm.

Workman's Comp, Liability, No Fault

If this visit was related to workman's compensation, liability or no fault, please call Claim Assist with auto, workers compensation or other liability insurance (slip and fall) information toll free at (800)875-5808 between 8:30 am and 5:00 pm.

Patient Accounts Hours

If you have any questions concerning your bill, you may call Patient Accounts at Yale New Haven Hospital between 8:30 am and 4:30 pm at (203)789-3227.

Please Note

This statement represents only the hospital bill. Charges for pathologists, radiologists, anesthesiologists, emergency department physicians, oncologists, surgeons, cardiologists and/or consultants ordered by your physician may be billed separately. These physicians groups are independent contractors and are NOT employees or agents of Yale New Haven Hospital.

Do We Have Your Insurance Information?

Complete this insurance information area only if information has not been previously provided or has changed

1. Primary Insurance: Patient Name _____ Insurance Co. Name _____ Insurance Co. Address _____ City/St _____ Zip _____ Phone _____ Policy # _____ Group # _____ Policy Holder's Name _____ Relationship _____ Policy Holder's S.S. # _____ Employer _____ 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. Please return with copies of the front and back of your insurance card(s). Signed _____	2. Secondary Insurance: Patient Name _____ Insurance Co. Name _____ Insurance Co. Address _____ City/St _____ Zip _____ Phone _____ Policy # _____ Group # _____ Policy Holder's Name _____ Relationship _____ Policy Holder's S.S. # _____ Employer _____ Date _____
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CHANGE OF ADDRESS Name _____ Address _____ City _____ State _____ Zip _____ List Other Family Members Included in Change _____	Effective Date of Change _____ Phone _____
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