MetroHealth

The MetroHealth System
PO Box 931703
Cleveland, OH 44193-1191

PAY THIS AMOUNT

$168.91

THIS IS YOUR HOSPITAL BILL.

Doctor services are billed separately.

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

Thank you for choosing the MetroHealth System for your healthcare needs. Please pay the amount currently due. You may also pay your bill online @ www.Metrohealth.org

PATIENT'S NAME

SAMPLE, PERRY

ACCOUNT NUMBER	MRN	BILL DATE	DUE DATE
X123456	X123456	6/11/07	7/02/07

CURRENT PRIMARY INSURANCE INFORMATION

Aetna Select Choice

DATE	DESCRIPTION	CHARGE	PAY / ADJ	BALANCE
12/10/09	EMERGENCY ROOM	$1,123.00		
12/10/09	LABORATORY	$340.00		
12/10/09	PHARMACY	$33.90		
12/26/07	MEDICARE PAYMENT		$195.83	
12/26/07	MEDICARE ADJUSTMENT		$1,132.16	$168.91
	SUBTOTALS	**$1,496.90**	**$1,327.99**	**$168.91**

PAY THIS AMOUNT

$168.91

PAYMENT OPTIONS:

1. **Check – Make checks payable to:** The MetroHealth System
Please write your account number on the check. Return the bottom portion with your payment in the enclosed envelope.
Note: A $25.00 charge will be added to your account for each check returned to us by your bank for nonsufficient funds.

2. **Credit Card –** Fill out your credit card information on the bottom portion of this statement and return it in the enclosed envelope.

3. **Online – Pay online at www.metrohealth.org**
ONLINE PAYMENT CODE: X123456789
(You will need this number to pay online.)

QUESTIONS ABOUT YOUR BILL?
Please call: (216) 957-3250
Toll free: (877) 509-0597
Monday – Thursday, 8:00am – 5:00pm; Friday 8:00am – 4:30pm

You may be eligible for financial assistance! *Please see the back of this statement for details.*

* Return this portion with your payment in the enclosed envelope *

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STATEMENT ENCLOSED

☐ To change name/address, check here and complete other side.

PATIENT'S NAME	ONLINE PAYMENT CODE
SAMPLE, PERRY	X123456789

ACCOUNT NUMBER	MRN	BILL DATE	DUE DATE
X123456	X123456	6/11/07	7/02/07

IF YOU ARE PAYING BY CREDIT CARD

CARD NUMBER ☐ VISA ☐ MasterCard ☐ DISCOVER

SIGNATURE | EXP DATE

PAY THIS AMOUNT $168.91

SHOW AMOUNT PAID HERE $

ADDRESSEE:

PERRY SAMPLE
12608 ELMWOOD AVE
LAKEWOOD OH 44107

MAKE CHECK PAYABLE AND REMIT TO:

THE METROHEALTH SYSTEM
PO BOX 931703
CLEVELAND, OH 44193-1191

HOW TO READ YOUR STATEMENT:

DATE refers to all dates when transactions (charges, payments, or credits) were made to your account.

PROVIDER is the person or organization responsible for the activity.

DESCRIPTION is what took place on that date, such as type of service performed or payment and/or credit made.

CHARGE is the amount charged for the service performed by the provider.

PAYMENT/ADJUSTMENTS is the amount by which the charge amount has been adjusted by a payment or other credit.

BALANCE is the amount you owe.

Visit our website at www.metrohealth.org

Make a payment
Find answers to Frequently Asked Questions
More information on the services provided by MetroHealth.

DETAILS ON FINANCIAL ASSISTANCE

In compliance with Ohio Hospital Care Assurance Program, MetroHealth Medical Center offers basic medically necessary hospital level services free of charge to individuals who are residents of the State of Ohio, are not recipients of the Medicaid Program and whose income is at or below the federal poverty line.

The current poverty guidelines issued by the secretary pursuant to 42 U.S.C. 9902 are as follows:

Family Size	Poverty Guideline	Family Size	Poverty Guideline
1	$10,890	5	$26,170
2	14,710	6	29,990
3	18,530	7	33,810
4	22,350	8	37,630

For families with more than eight members, add $3,820 for each additional member. In addition, MetroHealth System offers discounts on medically necessary services to residents of Cuyahoga County if you are at or below 400% of the Federal Poverty Level.

If you would like more information regarding financial assistance, please call (216) 957-2325.

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE BELOW.

ABOUT YOU

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY | STATE | ZIP

TELEPHONE ( ) | MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME | TELEPHONE ( )

EMPLOYER'S ADDRESS | CITY | STATE | ZIP

ABOUT YOUR INSURANCE

YOUR PRIMARY INSURANCE COMPANY'S NAME | EFFECTIVE DATE

PRIMARY INSURANCE COMPANY'S ADDRESS | TELEPHONE ( )

CITY | STATE | ZIP

POLICY HOLDER'S ID NUMBER | GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME | EFFECTIVE DATE

SECONDARY INSURANCE COMPANY'S ADDRESS | TELEPHONE ( )

CITY | STATE | ZIP

POLICY HOLDER'S ID NUMBER | GROUP PLAN NUMBER

FINANCIAL GUARANTEE AND ASSIGNMENT OF BENEFITS

I assign MetroHealth Medical Center all benefits due from any insurance organization on my behalf.

PATIENT'S SIGNATURE | DATE | INSURED'S SIGNATURE | DATE