Your Emory Physician Statement

1 **Primary Insurance Information** - The insurance company name, policy number, group number and policy holder that our records identify as your primary insurance information.

2 **Additional Insurance** – The insurance company name, policy number, group number and policy holder for any additional insurance information, if applicable.

3 **EPay Code** – EPay code to enter for online payments. See # 17

4 **Patient Name** – The name of the person who received services.

5 **Account Number** - Please write this number on your check when making payments. Also, refer to this number when making written or telephone inquiries about your account.

6 **Statement Date** – The day this statement was printed.

7 **Balance Due** – Total amount due at this time.

8 **Amount Paid** – Indicate the amount of your enclosed payment. Please make checks payable to **Emory Clinic**

9 **Service Date** – Date service was provided.

10 **Services Provided** – The doctor and department name that performed the service and a description of the services provided.

11 **Charge** – The fee charged for the service provided.

12 **Insurance Company** – The patient's health insurance plan.

EMORY CLINIC
EMORY MEDICAL LABS
EMORY SPECIALTY ASSOCIATES
PO Box 102398 · Atlanta, Georgia 30368-2398

For Questions Please Call: 404-778-7318
Call Toll Free: 1-800-511-4443
Hours: M-F 8:30am - 4:30pm

Insurance Information on File		
Insurance	Prim. Insurance	Addn. Insurance
Name		
Policy #	1	2
Group #		
Policy Holder		

If address is incorrect, please enter changes:

To pay by check, please make check payable to Emory Clinic
To pay by credit card, please complete the following:

Exp. Date _____ Payment _____
Card # _|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_

☐VISA ☐ MasterCard ☐American Express ☐Discover
Signature _____

"EPay" code: XXXX-XXXX-XXXX-XXXX 3

Patient Name: 4

Account #: 5

Statement Date: 6

Balance Due: 7

Amount Paid: ___ 8 ___

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN THE ENVELOPE PROVIDED

This statement covers charges provided by your physician. It does not cover hospital charges.

Service Date	Services Provided	Charge	Insurance Company	Payments	Other Credits	Insurance Balance	Patient Balance
9	10	11	12	13	14	15	16

To pay your bill online, visit www.emoryhealthcare.org/billpay and enter your "EPay" code: xxxx-xxxx-xxxx-xxxx 17

Patient Name: 4

Account #: 5

Previous Balance	New Services	Insurance Pending	Due Date	BALANCE DUE
18	19	20	21	7

13 **Payments** – The amount your insurance company paid.

14 **Other Credits** – Credits applied to your account based on the contract with your insurance carrier.

15 **Insurance Balance** – Charges in this column have been billed to your insurance or other third party but payment has not yet been received. You may be responsible for all or part of these charges.

16 **Patient Balance** – Total amount due at this time.

17 **Web Address** - To pay your bill online visit web address and enter your "EPay" code.

18 **Previous Balance** - The balance due from last month's statement.

19 **New Services** – Charges applied to your account during this statement period.

20 **Insurance Pending** - Current charges pending insurance processing.

21 **Due Date** - Payment due by this date.

If you have any questions, please feel free to contact Customer Service @ 404-778-7318 or @1-800-511-4443

EMORY HEALTHCARE