Your billing statement is now easier to understand!

Emory Hospitals account statements have a new look.

They are arranged logically to provide more information than statements you may have received for past accounts. Please note the following features:

EMORY HEALTHCARE

PO Box 2265
Norcross, GA 30091-2265
RETURN SERVICE REQUESTED

Emory University Hospitals

Patient Name: PATIENT, JOHN Q.

A

Please write your account number on your check.
Make check payable to Emory University Hospitals.

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.
CHECK CARD USING FOR PAYMENT
MASTERCARD DISCOVER VISA AMERICAN EXPRESS
CARD NUMBER | SECURITY CODE
SIGNATURE | EXP. DATE

DUE DATE	STATEMENT DATE	ACCT. #
03/19/2013	02/27/2013	12345678-0000

AMOUNT DUE	SHOW AMOUNT PAID HERE
$732.30	$

PATIENT, JOHN Q.
123 NORTH MAIN STREET
ANYTOWN, USA 12345-6789

EMORY UNIVERSITY HOSPITALS
PO BOX 403021
ATLANTA, GA 30384-3021

Check box if above address is incorrect and indicate change(s) on reverse side.

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

B

Your Statement

Thank you for choosing Emory Healthcare. This statement reflects a summary of charges from your visit. THIS IS NOT A BILL.

If other medical providers or physicians helped in your care, you will receive additional bills from them. Please check the information below. If your insurance is not listed below or is incorrect, please contact us IMMEDIATELY.

C

Account Summary

Statement Date	02/27/2013
Date of Service	02/09/2013 - 02/09/2013
Account Number	**00979770-3040**
Type of Service	Emergency
Total Charges	$732.30
Primary Insurance Payments Received	0.00
Secondary Insurance Payments Received	0.00
Patient Payments Received	0.00
Adjustment	0.00
This is your balance	**$732.30**

E

For Your Information

Please note this statement is for services at Emory University Hospitals. Charges for physicians services are billed on separate statements by The Emory Clinic or other physicians. If you have questions regarding your clinic account, please call 404-778-7318 or 800-511-4443 or the number on the statement.

F

Contact Us

Please call the Customer Service Department at **404-686-7041** or **800-827-7041** weekdays between the hours of 8:30 am and 4:00 pm. When inquiring about this account or when informing us of changes to personal information (insurance coverage, address, etc.), please indicate the Patient Account Number and Date of Service.

PAY BY PHONE: 855-851-7193

PAY ONLINE at:
https://emoryuh.ixt.com

A simple and easy way to access your updated account information and pay your accounts online.

D

Insurance Information

PRIMARY Insurance Name
Policy Number

SECONDARY Insurance Name
Policy Number

PLEASE SEE IMPORTANT INFORMATION LOCATED ON THE REVERSE SIDE OF THE STATEMENT.

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A Header
Includes patient's name and hospital billing for the services you received.

B Your Statement
A summary explanation of the statement you've received. This section is important because the message may vary with each statement you receive.

C Account Summary
Includes statement date, service date, total charges and current balance. If the statement is being sent shortly after the patient's date of service, it will be too soon to show insurance payment information.

D Insurance Information
Displays primary and secondary insurance name and policy/ID number we have for this account.

E For Your Information
Explains how to obtain additional information about your physician account, which is billed separately from the hospital account.

F Contact Us
Explains how to contact the hospital by phone as well as our two new services: Automated pay by phone and VIEW AND PAY YOUR ACCOUNT ONLINE!

G About You
How to notify us by mail of changes to patient name, address, phone number and other demographic information.

H About Your Insurance
How to notify us by mail of changes/additions to patient insurance information.

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST HOSPITAL VISIT, PLEASE INDICATE . . .

G 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

H ABOUT YOUR INSURANCE: (Please provide a copy of your card)
YOUR PRIMARY INSURANCE COMPANY'S NAME EFFECTIVE DATE
PRIMARY INSURANCE COMPANY'S ADDRESS PHONE
CITY STATE ZIP
POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER
YOUR SECONDARY INSURANCE COMPANY'S NAME EFFECTIVE DATE
SECONDARY INSURANCE COMPANY'S ADDRESS PHONE
CITY STATE ZIP
POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

Patient Name: JENKINS, WILTON M
Account Number: 00979770-3040
Date(s) of Service: 02/09/2013 - 02/09/2013
Page 2 of 2

PAYMENT POLICY
In order for Emory Healthcare to have financial resources to serve the community health care needs, payment in full is expected within 20 days of a statement.

Thank You!

BELOW IS THE SUMMARY OF CHARGES FOR YOUR HOSPITAL SERVICES.

Charge Summary Description	Total Charges	Charge Summary Description	Total Charges
Emergency Room	411.00		
Pharmacy	107.30		
Radiology - Diagnostic	214.00		
Total Charges	$732.30		

A Summary of Charges for your visit will be conveniently located on the back of your statement.

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This exciting new format takes effect for accounts with admit dates of March 16, 2013 and later. If you have accounts with admit dates prior to March 16, you will receive one summary bill and subsequent letter-style correspondence in the older format.

Thank you for choosing Emory Healthcare.

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