# UNDERSTANDING YOUR STATEMENT

The following explains each element of your bill.

1. Date:

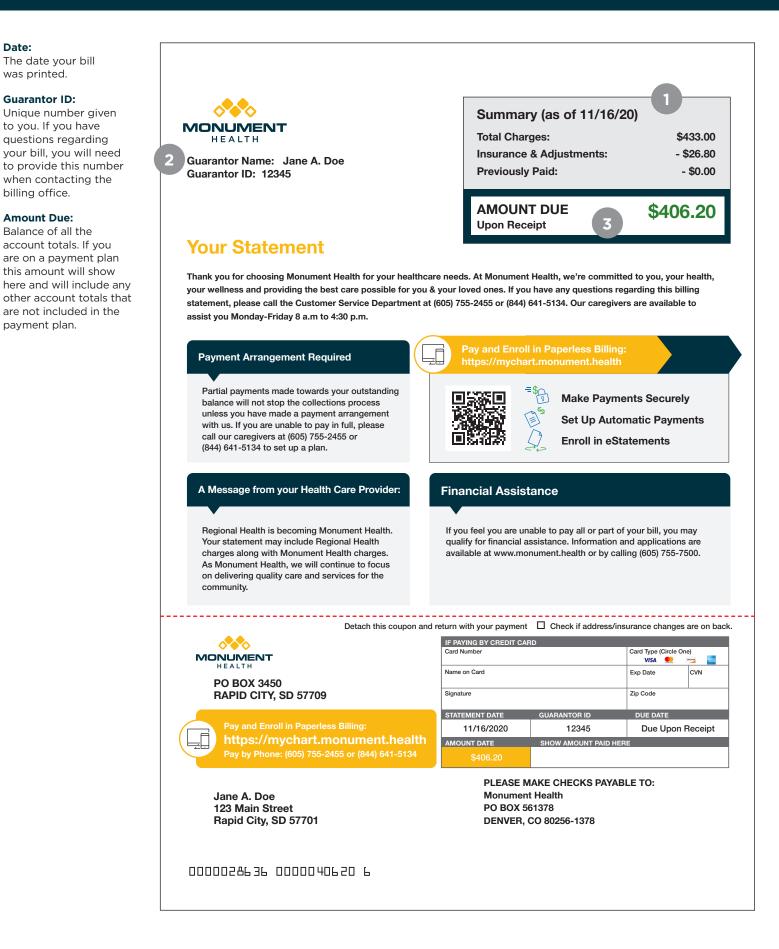
was printed. 2. Guarantor ID:

billing office.

payment plan.

3. Amount Due:





# UNDERSTANDING YOUR STATEMENT

The following explains each element of your bill.



#### 4. Service Date:

The date you received services.

### 5. Description:

A short phrase that appears on the initial statement and is an explanation of the services received.

#### 6. Charge:

This is the total amount charged directly to either you or your insurance provider.

#### 7. Account Number:

Unique number given to each of your dates of service.

# 8. Payment/Adjustments:

Any payments or adjustments that you or your insurance provider have already paid.

## 9. Total:

Balance for each account after payments and adjustments are applied.

# 10. Balance Total:

Balance for all accounts.

## 11. Final Notice:

This will let you know that this account has received 3 statements and you need to pay the balance in full or contact Monument Health to set up a payment arrangement.

	MONUMENT HEALTH			Guarantor Name: Jane A. Doe Guarantor ID: 12345 8					
	DATE	DESCRIPTI	ON			CHARGE	PAYMENTS/ ADJUSTMENTS	TOTAL	
J	Patient: Jane	A. Do 7	Account Number:	10000123456	(at Monument	Health Ne	urology & Rehab	ilitation)	
4	11/16/2020	Balance Fo	orward		6	\$124.80		9	
						\$124.80	\$0.00	\$124.80	
			(11)*FIN	IAL NOTICE FOR	THIS ACCOUNT	*			
	_	_		_					
	Patient: Jane A. Doe Account Number: 10000123456 11/16/2020 Balance Forward			(at Monument Health Rapid City Clinic) \$241.20					
	11/16/2020	balance FC	orward			\$241.20	\$0.00	\$241.20	
						\$241.2U	20.00	\$241.20	
	Patient: Jane A. Doe Account Number: 10000123456				(at Monument Health Rapid City Clinic)				
	11/16/2 5	COLLECTI	ON VENOUS BLOOD,	VENIPUNCTURE		\$7.00			
	11/16/2020	COLLECTI	ON VENOUS BLOOD,	VENIPUNCTURE		\$50.00			
	11/16/2020	11/16/2020 PR REF VIT D 25 HYDROXY W FRACTIONS				\$10.00			
	Patient Adj				ustments		( - \$26.80)		
						\$67.00	- \$26.80	\$40.20	
							10		
	Balance	Total					10	\$406.20	
	1								

If any of the following has changed since your last statement, please include:

Your Name (Last, First, Middle Initial)		Date of Birth	Your PRIMARY Insurance Company's Name				
four Name (Last, First, Middle mitial)		Date of Birth	Tour PRIMART Insurance Company's Name				
Address			Primary Insurance Company's Address				
City	State	Zip	City	State	Zip		
Telephone	Social Security #		Policyholder Name	Date of Birth	Sex		
Employer's Name	Telephone		Policyholder's ID Number	Group Plan Number			
Employer's Address			Your SECONDARY Insurance Company's Name				
City	State Zip Secondary Insruance Company's Address						
Please Indicate if Applicable: Auto Acc	cident 🛛 Worker's	s Compensation	City	State	Zip		
Date of Injury			Policyholder Name	Date of Birth	Sex		
			Policyholder's ID Number	Group Plan Number			

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