UNDERSTANDING YOUR STATEMENT

The following explains each element of your bill.

MONUMENT HEALTH

1. **Date:**
   The date your bill was printed.
2. **Guarantor ID:**
   Unique number given to you. If you have questions regarding your bill, you will need to provide this number when contacting the billing office.
3. **Amount Due:**
   Balance of all the account totals. If you are on a payment plan this amount will show here and will include any other account totals that are not included in the payment plan.

MONUMENT HEALTH

2

Guarantor Name: Jane A. Doe
Guarantor ID: 12345

1

Summary (as of 11/16/20)

Total Charges:	$433.00
Insurance & Adjustments:	- $26.80
Previously Paid:	- $0.00

AMOUNT DUE
Upon Receipt 3 **$406.20**

Your Statement

Thank you for choosing Monument Health for your healthcare needs. At Monument Health, we're committed to you, your health, your wellness and providing the best care possible for you & your loved ones. If you have any questions regarding this billing statement, please call the Customer Service Department at (605) 755-2455 or (844) 641-5134. Our caregivers are available to assist you Monday-Friday 8 a.m to 4:30 p.m.

Payment Arrangement Required

Partial payments made towards your outstanding balance will not stop the collections process unless you have made a payment arrangement with us. If you are unable to pay in full, please call our caregivers at (605) 755-2455 or (844) 641-5134 to set up a plan.

Pay and Enroll in Paperless Billing:
https://mychart.monument.health

- Make Payments Securely
- Set Up Automatic Payments
- Enroll in eStatements

A Message from your Health Care Provider:

Regional Health is becoming Monument Health. Your statement may include Regional Health charges along with Monument Health charges. As Monument Health, we will continue to focus on delivering quality care and services for the community.

Financial Assistance

If you feel you are unable to pay all or part of your bill, you may qualify for financial assistance. Information and applications are available at www.monument.health or by calling (605) 755-7500.

Detach this coupon and return with your payment ☐ Check if address/insurance changes are on back.

MONUMENT HEALTH

PO BOX 3450
RAPID CITY, SD 57709

Pay and Enroll in Paperless Billing:
https://mychart.monument.health
Pay by Phone: (605) 755-2455 or (844) 641-5134

IF PAYING BY CREDIT CARD		
Card Number		Card Type (Circle One) VISA
Name on Card	Exp Date	CVN
Signature		Zip Code

STATEMENT DATE	GUARANTOR ID	DUE DATE
11/16/2020	12345	Due Upon Receipt
AMOUNT DATE	**SHOW AMOUNT PAID HERE**	
$406.20		

Jane A. Doe
123 Main Street
Rapid City, SD 57701

PLEASE MAKE CHECKS PAYABLE TO:
Monument Health
PO BOX 561378
DENVER, CO 80256-1378

00000286 36 00000406 20 6

UNDERSTANDING YOUR STATEMENT

The following explains each element of your bill.

MONUMENT HEALTH

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

DATE	DESCRIPTION	CHARGE	PAYMENTS/ ADJUSTMENTS	TOTAL
Patient: Jane A. Do	**Account Number: 10000123456 (at Monument Health Neurology & Rehabilitation)**			
11/16/2020	Balance Forward	$124.80		
		$124.80	$0.00	$124.80
	FINAL NOTICE FOR THIS ACCOUNT			
Patient: Jane A. Doe	**Account Number: 10000123456 (at Monument Health Rapid City Clinic)**			
11/16/2020	Balance Forward	$241.20		
		$241.20	$0.00	$241.20
Patient: Jane A. Doe	**Account Number: 10000123456 (at Monument Health Rapid City Clinic)**			
11/16/2	COLLECTION VENOUS BLOOD, VENIPUNCTURE	$7.00		
11/16/2020	COLLECTION VENOUS BLOOD, VENIPUNCTURE	$50.00		
11/16/2020	PR REF VIT D 25 HYDROXY W FRACTIONS	$10.00		
	Patient Adjustments		(- $26.80)	
		$67.00	- $26.80	$40.20

Balance Total **$406.20**

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		
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 Accident** ☐ **Worker's Compensation**			City	State	Zip
Date of Injury			Policyholder Name	Date of Birth	Sex
			Policyholder's ID Number	Group Plan Number	