Penn Medicine

PO BOX 824406, PHILADELPHIA, PA 19182-4406

Return Service Requested

QUESTIONS? Telephone 800-406-1177 Mon-Fri 8:00 AM - 6:00 PM EST
Sat 9:00 AM - 1:00 PM EST

JOHN PATIENT
123 MAIN ST
PHILADELPHIA PA 19102

ACCOUNT SUMMARY

Statement Date:	2/25/2015
Patient Name:	JOHN PATIENT
Account Number:	123456789
Due Date:	03/25/2015
Total Charges:	$317.00
Amount You Owe:	**$170.26**
Details/Information on Reverse	

Insurance Information

Insurance 1	UNITED CHOICE DEFINITY SELECT
Insurance 2	No secondary insurance on file

Please indicate changes to insurance information on the reverse side of this form. If dental or vision insurance is listed above, that insurance is only billed for the applicable service.

ABOUT YOUR STATEMENT

Thank you for choosing Penn Medicine for your health care. This is a statement of your account(s) for Physician/Health Care Provider services only. You may receive a separate bill for Hospital, Ancillary or Laboratory services provided at several locations within the Health System.

The reverse side of this statement details the Physician/Health Care Provider involved in your care. For your convenience, the charge(s) for service(s) provided along with any payment(s) or adjustment(s) made to your account(s) has been itemized.

If you wish to pay by credit card, please complete the stub below and return it in the enclosed envelope or contact us at **800-406-1177** to pay by phone or online at **www.uphs247.com**. Most major credit cards are accepted as payment.

Penn Medicine provides urgently needed services to all persons without regard to their ability to pay. If you are having difficulty paying your bill, please contact us at **800-406-1177** to determine the type of funding for which you may be eligible or to make payment arrangements.

Our customer service representatives are available Mon-Fri between 8:00 AM and 6:00 PM EST and Sat between 9:00 AM and 1:00 PM EST.

IMPORTANT MESSAGE

Payments will be applied to the oldest open balance on your account, including any accounts that have been transferred to collections.

Please pay the amount due indicated on this statement upon receipt.

Please detach and return below portion with your payment

Penn Medicine

PO BOX 824406, PHILADELPHIA, PA 19182-4406

☐ VISA ☐ MasterCard ☐ American Express

CARD NUMBER	SECURITY CODE
AMOUNT CHARGED	EXP. DATE
NAME ON CARD (PLEASE PRINT)	
SIGNATURE	

REMITTANCE SECTION

Patient Name:	JOHN PATIENT
Account Number:	123456789
Due Date:	03/25/2015
Amount You Owe:	**$170.26**

Amount Enclosed: $ _____

Make checks payable to: PENN MEDICINE

PENN MEDICINE
PO BOX 824406
PHILADELPHIA PA 19182-4406

8244060000030270245000001702608863983O

Penn Medicine

Statement Date: 2/25/2015
Patient Name: JOHN PATIENT
Account Number: 123456789

SUMMARY OF SERVICES AND CHARGES

Date of Service	Posting Date	CPT Code	Department/Description	Provider / Mid-Level Provider	Charges	Payments/ Adjustments	Amount You Owe
			Department of Radiology				
08/07/14		73562	X-RAY KNEE 3 VIEW	BORISLOW MD, S	32.00		
	08/28/14		INSURANCE PAYMENT			0.00	
	01/28/15		CONTRACTUAL ADJUSTMENT			-13.00	
			PATIENT RESPONSIBILITY				**$19.00**
			Department of				
01/12/15		11301	SHAV SKIN LES 6-10MM	BONDI MD, E	285.00		
	01/28/15		INSURANCE PAYMENT			0.00	
	01/28/15		CONTRACTUAL ADJUSTMENT			-133.74	
			PATIENT RESPONSIBILITY				**$151.26**

Total Charges:	$317.00
Amount You Owe:	**$170.26**

IF YOU HAVE A NEW ADDRESS OR INSURANCE INFORMATION PLEASE COMPLETE AND RETURN THE BOTTOM PORTION.

Patient Information

Your Name (Last, First, Middle Initial) Date of Birth

Address

City State Zip

Telephone

Employer's Name Telephone

Employer's Address

City State Zip

Insurance, HMO or Other Payor Information-New/Change

Insurance Co. Telephone #

Street

City State Zip

Policy Holder

Policy #

Group #

Employer