Hackettstown Medical Center
ATLANTIC HEALTH SYSTEM

Hackettstown Medical Center
33 Wood Avenue South, Suite 840
Iselin, NJ 08830-2717

99xxxxx X3
Statement Date: 01/06/2018

**********SNGLP 07099 1 170
Patrick W. Patient
101 Avenue A
Anytown NJ 07900

Patient Billing Statement

Patient Name	PATRICK W. PATIENT
Account Number	99xxxxx
Date of Service	08/19/2016-08/19/2016
Total Charges	$8,012.00
Insurance Payments	-$474.72
Insurance Adjustments	-$7,388.11
Patient Payment	$.00
Amount You Owe	$149.17

Final Notice

Dear Patrick W. Patient,

Although we have sent you several past-due reminders, your account remains unpaid. Regrettably, we have no choice but to refer this balance to a collection agency for further action unless a payment is received in the next 10 days.

Kindly remit your payment by detaching the form at the bottom of this letter. Be sure to include your account number on your check or money order so that we may properly credit your account. For credit card transactions, please include your signature along with your credit card number. Credit card payments can also be made by calling **1-844-201-3865**.

If any of the insurance information listed is incorrect, please complete the form on the reverse side of this letter and return it to us as soon as possible so that we may properly bill your health plan.

If you have any questions, concerns or would like to set up a payment plan. Please contact our Customer Service Department at **1-844-201-3865**.

Sincerely,
Patient Financial Services

Insurance Information

Insurance 1 ID Number	PRIMARY INSURER 10000xxxA
Insurance 2 ID Number	SUPLEMENTAL INSURER 100XXX0E

Questions

Billing questions or changes in coverage?
Call 1-844-201-3865 weekdays
8:30 am to 6:00 pm M -THURS
8:30 am to 4:30 pm FRI

Financial assistance may be available to you under Atlantic Health Sysytem's Financial Assistance Policy ("FAP"). You can obtain information about the FAP and the FAP application process by calling Hackettstown Medical Center's Financial Counseling office at 1-908-850-6902. You may obtain copies of the FAP documents by visiting:
www.atlantichealth.org/financialassistance

Date of Service: 08/19/2016-08/19/2016
Patient Name: PATRICK W. PATIENT

MAKE CHECKS OR MONEY ORDERS PAYABLE TO:

Hackettstown Medical Center
651 Willow Grove Street
Hackettstown, NJ 07840-1798

Patient Name	Account Number
PATRICK W. PATIENT	99xxxxx
Amount Due	**Amount I Am Paying**
$149.17	$

☐ VISA ☐ MasterCard ☐ DISCOVER ☐

Account No. _____
Expiration Date _____ CCV _____
Signature X _____

Summary of Services

Date of Service	Description of Services	Charges
08/19/2016-08/19/2016	Other Laboratory	$1,339.00
08/19/2016-08/19/2016	Drugs Requiring Detailed Codin	$27.00
08/19/2016-08/19/2016	Emergency Room	$1,804.00
08/19/2016-08/19/2016	Iv Therapy	$622.00
08/19/2016-08/19/2016	Other Ct Scans	$2,705.00
08/19/2016-08/19/2016	Sterile Supply	$58.00
08/19/2016-08/19/2016	Ekg / Ecg (Electrocardiogram)	$376.00
08/19/2016-08/19/2016	Other	$1,081.00

TOTAL CHARGES: **$8,012.00**

For Your Information

This Statement represents hospital charges only.

You may receive separate statements for radiologist services, or from your physician, surgeon, anesthesiologist, emergency room physician or pathologist. Please contact their offices directly if you have questions concerning their statements.

Do We Have Your Insurance Information?

Complete this insurance information area only if information has not been previously provided or has changed

1. Primary Insurance: ☐ Medicare ☐ Medicaid ☐ Blue Cross ☐ Other

Patient Name _____

Insurance Co. Name _____ Effective Date

Insurance Co. Address _____

City/St _____ Zip _____ Phone _____

Policy # _____ Group # _____

Date of Birth _____

Policy Holder's Name _____ Relationship _____

Policy Holder's S.S. # _____ Employer _____

2. Secondary Insurance: ☐ Medicare ☐ Medicaid ☐ Blue Cross ☐ Other

Patient Name _____

Insurance Co. Name _____ Effective Date

Insurance Co. Address _____

City/St _____ Zip _____ Phone _____

Policy # _____ Group # _____

Date of Birth _____

Policy Holder's Name _____ Relationship _____

Policy Holder's S.S. # _____ Employer _____

I authorize the hospital to submit any or all medical data to my insurance company, and authorize the assignment of any benefits or payments to the hospital. I understand I am financially responsible to the hospital for charges not covered by this authorization. Please return with copies of the front and back of your insurance card(s).

Signed _____ Date _____

CHANGE OF ADDRESS

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____