Atlantic Health System

Morristown Medical Center
P.O. Box 35610
Newark, NJ 07193-5610
Address Service Requested

A1002xxxxx0 Q1
Statement Date: 07/03/2016

MOR102 449775 567733689
Patrick W. Patient
101 Avenue A
Anytown NJ 07900

Patient Billing Statement

Patient Name	Patrick W. Patient
Account Number	A1002xxxxx0
Date of Service	01/20/2016 - 01/20/2016
Total Charges	$441.00
Insurance Payments	$0.00
Insurance Adjustments	-$416.99
Patient Payment	$0.00
Amount You Owe	**$24.01**

REMINDER NOTICE

Dear Patrick W. Patient,

Thank you for trusting Morristown Medical Center, a division of Atlantic Health, for your health care needs.

Your insurance carrier(s) have either paid a portion of, declined or ignored our request for payment on this account. The balance of $24.01 is now your responsibility.

Kindly remit your payment by detaching the form at the bottom of this letter or by accessing our website: **http://myhealth.atlantichealth.org**. 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.

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 **1-800-619-4024**.

Sincerely,
Patient Financial Services

Insurance Information

Insurance 1	PRIMARY INSURER
ID Number	10000xxxA

Questions

Billing questions or changes in coverage?
Call 1-800-619-4024 weekdays
8:30 am to 8:00 pm M - THURS
8:30 am to 4:30 pm FRI

Patient Website, 24 hours, 7 days per week:
http://myhealth.atlantichealth.org

Financial assistance may be available to you under Atlantic Health System's Financial Assistance Policy ("FAP"). You can obtain information about the FAP and the FAP application process by calling Morristown Memorial Hospital's Financial Counseling office at 1-973-971-8964. You may obtain copies of the FAP documents by visiting www.atlantichealth.org/financialassistance

Need to update your insurance information?

Date of Service: 01/20/2016

Patient Name: Patrick W. Patient

Patient Name	Account Number
Patrick W. Patient	A1002xxxxx0
Amount Due	**Amount I Am Paying**
$24.01	$

MAKE CHECKS OR MONEY ORDERS PAYABLE TO: Morristown Medical Center

MORRISTOWN MEDICAL CENTER
P.O. BOX 35610
NEWARK NJ 07193-5610

☐ VISA ☐ MasterCard ☐ DISCOVER ☐ AMERICAN EXPRESS

Account No. _____

Expiration Date _____

Signature X _____

Summary of Services

Date of Service	Description of Services	Charges
01/20/2016-01/20/2016	RAD DIAGNOSTIC	$441.00
TOTAL CHARGES:		**$441.00**

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 _____