Boulder Community Health
Patient Financial Services
P.O. Box 9049
Boulder, CO 80301-9049

BOU10F 15635 12265654

Test Test
12345 ST
City , State 00000

Account Summary

Statement Date:	2/18/2019
Account Number:	N000012345
Patient Name:	TEST TEST
Service Date:	9/28/2018
Total Charges:	$3130.00
Adjustments and Payments:	$2128.00
What You Owe Now:	$1002.00

Patient Services Provided

Description	Amount
450 EMERGENCY ROOM GENERAL	$3130.00
Payments:	$250.00
Adjustments to date:	$1878.00
Total due:	$1002.00

Important Message

Your insurance carrier has made its benefit determination or payment on your account and the remaining balance is now your responsibility. If you are unable to make payment in full or need Financial Assistance, please call (303) 415-4700 for programs that may be available to you, to request a copy of the Financial Assistance Application be mailed to you or if you need a copy of Financial Assistance Application translated in Spanish, or to make payment arrangements. If you have already sent your payment in, please accept our thanks.

- To see our complete Financial Assistance and Patient Payment Responsibility Policy, please go to www.bch.org or call (303) 415-4700
- Para obtener infomacion acerca de la asistencia financier, porfavor visite www.bch.org o 'llame al (303) 415-4758.

Insurance Information

Please notify us if the information below is not correct:

Primary Insurance:

Insurance:

ID Number:

Secondary Insurance:

No secondary insurance is on file. Please provide billing information if you have a secondary insurance.

Inquiries / Changes / Updates

- Billing questions or changes in insurance?
  Ph: (303) 415-4700 9am-4pm weekdays except Thursdays 11am-4pm
  Walk-In Hours: 10am-4pm weekdays except Thursdays 11am-4pm
  Espanol: (303) 415-4758
- Written Correspondence
  Patient Financial Services
  P.O. Box 9049
  Boulder, CO 80301-9049
- Fax: (303) 415-4701
- E-Mail: patientaccounts@bch.org

*Para Ayuda en Español llame al Numero (303) 415-4758

Statement Date: 2/18/2019

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Patient Financial Services
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Boulder, CO 80301-9049

Patient Name	Account Number	Date Due
Test, Test	N0000 12345	2/19/2019

Amount Now Due	Amount I Am Paying
$ 1002.00	$

☐ Check here if your address or insurance information has changed. Please indicate changes on the back of this page.

To pay by credit card: For your convenience, you may pay by Visa, MasterCard, Discover, and American Express. Please indicate your credit card preference, provide the Credit Card #, and sign below. Or you may call (303) 415-4700.

☐ VISA ☐ MasterCard ☐ DISCOVER ☐ AMERICAN EXPRESS

Credit Card Acct# _____

Print Card Holder Name _____

Expiration Date _____

Signature X _____

REMIT THIS PAYMENT STUB TO:

Boulder Community Health
Patient Financial Services
P.O. Box 9049
Boulder, CO 80301-9049

Payment Policy

To see our complete Financial Assistance and Patient Payment Responsibility Policy, please visit www.BCH.org.
Boulder Community Health offers a Financial Assistance Program (FAP). Eligibility for this program is determined by Total Family Income, insured status and amount due. If you are eligible for discounted care under the FAP, you will not be responsible for more than is generally paid by commercial insurers for emergency or other medically necessary care. The FAP and FAP application may be found at www.bch.org. A paper copy of the FAP and FAP application can also be obtained at our facility located at 4747 Arapahoe, Boulder, CO 80303 or 5450 Western Ave, Boulder, CO, 80301. You may contact our Financial Counselors at 303-415-8115 or Customer Service at 303-415-4700 for information regarding eligibility for the programs that may be available to you, to request the FAP or FAP application be mailed to you, or if you need a Spanish translation of the FAP or FAP application.

Regarding Your Statement

Your statement lists services billed and payments received since your last statement. You may receive more than one statement each month. When making a payment please return the lower portion of the statement. You will receive a separate bill from physicians (including radiologists, anesthesiologists, surgeons, etc.) involved in your care.

Insurance Coverage

Your primary insurance claim will be submitted to your insurance carrier by Boulder Community Health. The insurance company will send the explanation of benefits (EOB) to the policyholder. Please follow up with your insurance company representative if no response is received within 30 days. A prompt response to their request for updated information is appreciated. We will bill your secondary insurance claim as a courtesy.

Because some insurance companies take considerable time to process claims, your statement may not reflect the total amount you owe. Please do not disregard any hospital billings: keep all documentation received from your insurance company. Maintaining your own billing file will help you understand what portion of your account the hospital may be required to ask you to pay.

Managed Care Members

As explained in your policy, co-payments are required at the time of service.

Worker's Compensation

If you believe these charges are related to Worker's Compensation coverage please provide written authorization from your employer immediately.

Medicare

Boulder Community Health accepts Medicare assignment. We will submit your claims both to Medicare and to your supplemental insurance. You are responsible for any part of the Medicare approved amount not paid by Medicare. Examples of non-covered services are annual physical exams, some lab and x-ray services, and hearing aids. Please check with your supplemental insurance carrier if you feel they have not paid correctly. Your statement has been adjusted to reflect Medicare pricing.

Do We Have Your Insurance Information?

Accurate insurance information helps ensure prompt payments by your insurance company. Complete this insurance information area only if information has not been previously provided or has changed.

☐ Medicare ☐ Blue Cross ☐ Other Insurance ☐ Medicaid

Insured Name: Relation to Pt.: Insurance Co. Name:

Insured SSN: Insured Date of Birth: Insurance Co. Address:

Group #: Policy #: Insured Employer: Insurance Phone #:

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.

Signed_____ Date _____

CHANGE OF ADDRESS (Please Print Legibly)

Name _____

Address _____

City _____ State _____ Zip _____