

Understanding Your Group Health Medical Billing Statement



The name and ID number of the person normally financially responsible for the bill.


Accounts previously billed will now be marked with an * and will continue to show on future statements until paid.

The date services were provided.

The age of balances owing is shown. Any balance over 90 days may be sent to an outside collection agency.

Check this box if you've had changes to your address or insurance information. Complete the form on the back of the payment coupon. If paying by phone, tell us about any changes when you make your payment.

You can make a payment by detaching the payment coupon and mailing it with either a check or credit card information. You may also make credit card payments by phone at the number listed on the back of your statement.



BILLING STATEMENT

GroupHealth.

Guarantor Name: Caroline Cedargrove
 Guarantor ID: 5599
 Statement Date: 09/04/09

To contact us about your statement:
 Questions: (888) 901-4636
 TTY/TTD: (800) 833-6388
 www.ghc.org/customerservice

CAROLINE CEDARGROVE
 441 S AIRPORT RD
 SEATTLE WA 98128

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Date of Service	Account Activity *Account shown on prior statement	Charges	Payments/ Adjustments	Patient Balance
08/18/09	Account #7000619 Caroline Cedargrove Provider Visit 09/03/09 Payment, Group Health Pt.Resp: \$15.00 Copay	182.00	-167.00	15.00
Total		182.00	-167.00	15.00

0-30 Days	31-60 Days	61-90 Days	Over 90 Days	Payment Due Date:	09/19/09
15.00	0.00	0.00	0.00	New Balance Due:	15.00
				For This Statement Period You Owe:	15.00

All payments will be applied to oldest charges first unless otherwise indicated. Please retain statement for your records. See reverse side for bill explanation.

DETACH AT PERFORATION AND RETURN THIS PORTION WITH YOUR PAYMENT

FOR OTHER PAYMENT OPTIONS SEE REVERSE SIDE

Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

IF PAYING BY MASTERCARD, DISCOVER OR VISA, FILL OUT BELOW

CHECK CARD USING FOR PAYMENT

MASTERCARD DISCOVER VISA

Card Number: _____ Exp. Date: _____

Print Cardholder Name: _____

Cardholder Signature: _____

Guarantor Name: Caroline Cedargrove
 Guarantor ID: 5599
 Statement ID: 50017213
 Statement Date: 09/04/09

Due Date: 09/19/09
 You Owe: \$15.00
 Amount Paid: _____

MAKE PAYMENT TO:



PATIENT FINANCIAL SERVICES
 PO BOX 34283
 SEATTLE WA 98124-1283

0-0409 0050017213 0000005599 00001500 7 EPPCF3

The **Account Activity** section will include the following:

- Unique account number for specific charges
- Name of patient who received services
- Type of service provided
- Date of any patient payments
- Name of insurance company billed, with the date and type of payments or allowable adjustments.
- Amount and reason for any remaining patient balances on the account.

Charges, payments/adjustments and remaining patient balance are listed separately for easier identification.

The current balance owing and due date.

If you are using your bank's online bill paying service, please list the Statement ID # in the 'Memo' field so we can apply your payment correctly.

Make checks payable to: **Patient Financial Services** and mail to the address listed.