



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

CHECK CARD USING FOR PAYMENT

MASTERCARD  DISCOVER  VISA

CARD/CHECK NUMBER	1	AMOUNT
SIGNATURE		EXP. DATE
STATEMENT DATE	PAY THIS AMOUNT	GARRANTORID/SUBSCRIBERID

PAGE: 1 OF 1

SHOW AMOUNT PAID HERE \$

PATIENT ACCOUNT NUMBERS:

2

REMIT TO:

ADDRESSEE



GUARANTOR NAME  
ADDRESS  
CITY, STATE ZIP

4

3

PATIENT FINANCIAL SERVICES  
P.O. BOX 34581  
SEATTLE, WA 98124

BILLING STATEMENT

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

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

GUARANTOR ID/SUBSCRIBER ID.	STATEMENT DATE	AMOUNT DUE	DATE DUE
4	5	6	7

ACCOUNT NUMBER	ACCOUNT ACTIVITY	PATIENT NAME	ACCOUNT ACTIVITY	AMOUNT
8	9		10	11

1. Location to enter check and credit card information, which helps to ensure accurate account posting.
2. The internal reference number(s) used to identify a specific visit or service. This identifies which account(s) payments should be applied to.
3. Name of billing form.
4. Reflects the number and name of the person who is financially responsible for the bill.
5. Reflects the date the statement was produced.
6. Reflects the dollar amount due.
7. Reflects the date the statement balance is due.
8. The internal reference number (s) used to identify a specific visit or service received.
9. Reflects the date(s) of visit or service and/or date(s) related to payment(s) and adjustment(s).
10. Reflects transactions related to an account number. Contains description of services provided.
11. Reflects the amount of charge, adjustment, consumer payment, and/or insurance payment.
12. Reflects the dollar amount due.

For additional information, please refer to back of bill.

For Questions, please call Customer Service between 8 a.m. – 5 p.m.  
Monday – Friday 1-888-901-4636  
TTY/TTD Relay Service: 711 or 1-800-833-6388  
Or www.ghc.org or E-mail info@ghc.org

TOTAL DUE 12

