



Account Information

Patient Name MRS. PATIENT	
Account Number 999999999	Type of Service Outpatient
Statement Date 06/17/08	Service Date 06/02/08

Mrs. Patient
101 Any Street
Any Town, USA 12345



Important Message:

Thank you for choosing Self Regional Healthcare. Quality patient care and your satisfaction are our highest priorities.

A claim has been filed to the below insurance plan(s). Please allow 30 days processing. Once we receive a response from your insurance carrier, we will bill you for any co-insurance, deductible, co-pay, denied and/or non covered services.

If the insurance information listed below is not correct, please contact a Patient Financial Services Representative at 864-725-7800, Monday - Friday 8:30 a.m. to 5:00 p.m.

Payment is not expected from you at this time.

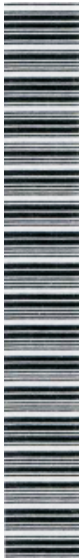
Insurance Information

Insurance Company	ID Number
MEDICARE	1234567
STATE HEALTH	12345A

Description

Amount

Mammography	140.25
Total Charges	140.25
Awaiting Insurance Response	140.25
Insurance Paid	0.00
Adjustments	0.00
Patient Paid	0.00



Please check here for address or name changes and indicate changes on the back of this form.



Welcome to our new statements!

As a result of suggestions by patients, Self Regional Healthcare's statements have been revised to better serve your needs.

Thank you for your suggestions and continued support.

Other Bills You May Receive

As a patient of Self Regional Healthcare, you may receive additional bills from your physician(s) who assisted in your care or reviewed your results. Physicians bill for their services separately. For your convenience, we have listed several common physician services below.

Upper Savannah Radiology	864-943-2170	Montgomery Center for Family Medicine	864-725-4865
Carolina Pathology Associates	864-227-8666	ER/Express Care Physician Billing	888-634-5211
Western Carolina Psychiatric	864-227-3908	Anesthesiology of Greenwood	864-227-3330

Key Terms

Adjustments	A portion of your bill that the hospital has agreed not to charge you.
Amount Not Covered	This is what your insurance company does not pay. This includes your deductible, co-insurance, co-pay, and charges for uncovered services.
Assignment of Benefits	The approval for your insurance company to make payment directly to the hospital.
Deductible	How much cost sharing that you must pay for medical services before your insurance company starts to pay.
Co-insurance	The percentage of the bill that is paid by the insured individual after the deductible is met. This amount is determined by your health insurance plan.
Co-payment	Typically a predetermined (flat) fee amount that is the insured's responsibility for a specific service. This amount is determined by your health insurance plan.
Total Charges	Total amount of the hospital facility charges.
Coordination of Benefits (COB)	Process of determining payment amount due when a patient is covered by more than one insurance company.
Explanation of Benefits (EOB)	Notification from the insurance company explaining the payment made and what the patient must pay.

If any information below has changed, please indicate and return.

About You:

Your Name (Last, First, Middle Initial)		
Address		
City	State	Zip
()		
Telephone	E-mail Address	
	()	
Employer's Name	Telephone	
Employer's Address		
City	State	Zip

About Your Insurance:

Your Primary Insurance Company's Name	Effective Date
Primary Insurance Company's Address	Phone
City	State Zip
Policy Holder's Id Number	Group Plan Number
Your Secondary Insurance Company's Name	Effective Date
Secondary Insurance Company's Address	Phone
City	State Zip
Policy Holder's Id Number	Group Plan Number