Harborview Medical Center
PO Box 34570

The top portion of statement is for your records and shows where you were treated.

UW Medicine
HARBORVIEW MEDICAL CENTER

00002

JOHN DOE SAMPLE
12345 MY STREET
MY CITY WA 98000-1234

Summary for Patient: SAMPLE, JOHN DOE

Total Charges	
Total Insurance Paymen	
Total Adjustments	
Total Patient Payments	
Total Patient Responsibi	

This is a quick summary of your account with the total charges, payments, adustments, and amount you need to pay now.

Total Payment Plan Balance	$0.00
Payment Plan Amount Due	$0.00
Total Amount Due by 12/03/2011	**$275.15**

Please see reverse for detailed account information.

This area shows what insurance coverage we have for your account

Secondary: None

If your insurance coverage has recently changed, or you have coverage not listed above, please complete the CHANGE OF INSURANCE section on back of the statement.

This area shows important information on how to set up a payment plan or apply for financial aid. It also contains information on when your payment is due.

redit and debit cards. To pay by phone or set up a monthly payment plan, call
you qualify for Financial Assistance.

nly statement if you have a balance due on your account. The patient responsibility shown is due and payable within 21 days unless prior special payment terms have been arranged. Your payments will be posted to the oldest dates of service first. If you wish to pay for a specific visit, please call our Customer Service Department and use your credit or debit card.

Questions?

Billing questions, changes in insurance coverage or address? Please contact our Customer Service Office.
Hours of operation, 8:00am - 5:00pm Monday - Friday
Toll Free (800) 304-9645
Correspondence can be sent to: UWMC - Patient Financial Service, PO Box 34735, Seattle WA 98124-1737

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The bottom portion of the statement needs to be returned with your payment so we can apply your payment quickly and accurately.

MAKE YOUR CHECK PAYABLE TO:

University of Washington Medical Center
PO Box 34735
Seattle WA 98124-1737

Guarantor: JOHN DOE SAMPLE	**Statement Date:** 11/12/2011
Guarantor Number 2054739	**Date Due** 12/03/2011
Amount Due $275.15	

You can pay your account by check, credit or debit card. If you are paying by or debit card, please be sure to fill out the required information. Please do not send cash in the mail. You may pay with cash at the Hospital Cashier's office.

☐ VISA

Cardholder Name _____

Card Number _____

Expiration Date _____

Signature _____

☐ Check box if your insurance or address has recently changed and complete the form on the back of this stub.

020 000141660 000141660 00000002054739 8 6