

Statement Date: 10/31/2018

JOHN HUMANA  
1234 STATEMENT WAY  
SEATTLE, WA 98101

Summary for patient: HUMANA,JOHN

Total Charges	\$505.00
Total Insurance Payments	\$0.00
Total Adjustments	\$0.00
Total Patient Payments	\$0.00
Total Patient Responsibility	\$505.00
Total Payment Plan Balance	\$0.00
Payment Plan Amount Due	\$0.00

**Total Amount Due By 11/30/2018 \$505.00**

Please pay amount due within 30 days of the statement date.

If you need help paying your bill, whether or not you have insurance, you may qualify for financial assistance. For more information, see our website at [www.uwmedicine.org/financialassistance](http://www.uwmedicine.org/financialassistance) or call (206) 668-6440.

Si necesita ayuda para pagar su factura, tenga o no tenga seguro, usted puede ser considerado para recibir asistencia financiera. Para obtener más información, visite nuestro sitio web en [www.uwmedicine.org/financialassistance](http://www.uwmedicine.org/financialassistance) o llame al (206) 668-6440.

**For your convenience, Northwest Hospital offers online bill pay at:  
[www.nwhospital.org/visitorinfo/billing.asp](http://www.nwhospital.org/visitorinfo/billing.asp)**

Please contact Customer Service at (206) 668-6440 or toll free (877) 364-6440 if you have questions regarding your statement. See the back of this page for additional contact options.

If your insurance coverage has recently changed or you have coverage not listed with your accounts in the detailed (gold) section, then please complete the CHANGE OF INSURANCE section on the back of this statement and mail it in, or call the Customer Service office at one of the numbers listed above.

**RETAIN THIS PORTION OF YOUR STATEMENT FOR TAX PURPOSES**

**UW Medicine** Patient Financial Services  
NORTHWEST HOSPITAL & MEDICAL CENTER 10330 Meridian Ave N Ste 260  
Seattle, WA 98133

**RETURN SERVICE REQUESTED**

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

JOHN HUMANA  
1234 STATEMENT WAY  
SEATTLE, WA 98101

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.		
CHECK CARD USING FOR PAYMENT		
<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> VISA
<input type="checkbox"/> AMERICAN EXPRESS		
CARD NUMBER	SECURITY CODE	
SIGNATURE		EXP. DATE
GUARANTOR NUMBER 0123456	STATEMENT DATE 10/31/2018	DUE DATE 11/30/2018
AMOUNT DUE <b>\$505.00</b>	AMOUNT ENCLOSED <b>\$</b>	

**MAKE CHECKS PAYABLE TO:**

NORTHWEST HOSPITAL & MEDICAL CENTER  
PO BOX 24998  
SEATTLE, WA 98124-0998