

**Stanford Hospital & Clinics**  
**Lucile Packard Children's Hospital**  
**Patient Financial Services**  
2690 Hanover Street  
Palo Alto, CA 94304

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Lucile Salter Packard  
Children's Hospital

STANFORD UNIVERSITY MEDICAL CENTER

# *Entienda su Estado de Cuenta*



## Entienda su Estado de Cuenta

Stanford Hospital & Clinics y Lucile Packard Children's Hospital han diseñado este folleto para ayudarle a entender las facturas y centrar su atención en la información esencial.

Las tres facturas que se explican en este folleto son:

**Estado de cuenta del Hospital** – Factura para una cuenta individual según el tipo de servicio que ha recibido en el hospital (p.ej. hospitalización, visita a la sala de emergencia, servicios mensuales recibidos por una consulta interna y/o externa.)

**Estado de cuenta Mensual del Hospital** – Factura mensual consolidada que incluye la actividad de su(s) cuenta(s) individual(es) pendiente(s) con el hospital

**Estado de cuenta del Médico** – Esta factura incluye los servicios que Usted ha recibido de los médicos en Stanford Hospital & Clinics y en Lucile Packard Children's Hospital

Según el tipo de servicio(s) que haya recibido, recibirá facturas independientes del Stanford Hospital & Clinics, del Lucile Packard Children's Hospital (que incluirá los servicios de radiólogos, cirujanos, anestesistas y otros especialistas), así como de otras personas que le hayan prestado algún servicio.

Enviaremos la factura a su seguro principal, si corresponde, a su compañía de seguros secundaria por cortesía. Es importante recordar que varían los servicios que cubre el seguro y algunos servicios pueden no estar cubiertos. Los co-pagos, el co-seguro, los deducibles y los servicios no cubiertos serán su responsabilidad según su cobertura del seguro médico.

## Número de Teléfono de Servicios al Cliente

Si tiene alguna pregunta o comentario sobre su(s) factura(s), póngase en contacto con el Departamento de Servicios al Cliente que corresponda:

### Stanford Hospital & Clinics

[www.stanfordhospital.com](http://www.stanfordhospital.com)

Lunes - Viernes, 8:00 am - 5:00 pm  
(800) 333-7491 or (650) 498-7200

### Lucile Packard Children's Hospital

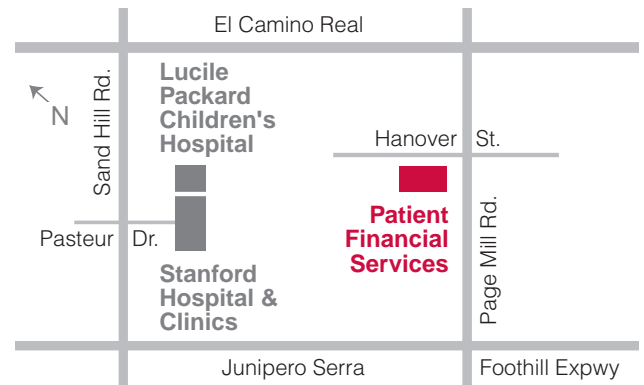
[www.lpch.org](http://www.lpch.org)

Lunes - Viernes, 8:00 am - 5:00 pm  
(800) 308-3285 or (650) 473-3938

### Facturas de médicos de Stanford y de Packard

Lunes - Viernes, 9:00 am - 12:30 pm and 1:30 pm - 4:00 pm  
(800) 549-3720 or (650) 498-5850

Si prefiere discutir su (s) factura(s) personalmente, nuestro personal de servicios al cliente estará disponible para atenderle de las 8:00 am - 4:00 pm, de lunes a viernes. La oficina de Servicios Financieros de los Pacientes está en 2690 Hanover Street en Palo Alto, CA.



# Estado de cuenta del hospital – página 1

Clave de información importante incluida en su estado de cuenta

- A** - Número de Cuenta (Account Number)
- B** - Importe Pendiente de Pago (Amount Due from You)
- C** - Fecha de Límite de Pago (Date Payment is Due)
- D** - Fecha[s] de Servicio (Date[s] of Service)
- E** - Actividades de Pago y de Crédito (Payment and Credit Activity)
- F** - Información Sobre su Seguro Médico (Insurance Information)



Lucile Salter Packard  
Children's Hospital

Stanford University Medical Center

STANFORD UNIVERSITY MEDICAL CENTER

Recibirá un estado de cuenta separado del Lucile Packard Children's Hospital y del Stanford Hospital & Clinics

SAMPLE A. SAMPLE  
123 MAIN ST  
ANYTOWN, XX 12345-1234

### Hospital Account Summary

Statement Date	06/18/2004
Service Date(s)	04/17/1997
<b>A</b> Account Number	999999999999
Total Charges	\$ 2,570.26
Patient Payments	\$ 0.00
Insurance Payments	\$ 0.00
Insurance Adjustments	\$ 0.00
Other Adjustments*	\$ 0.00
<b>C</b> Balance Due Upon Receipt	\$ 2,570.26

### Insurance Information

Please confirm that the information is correct for:

Patient Name	SAMPLE A. SAMPLE
Medical Record No.	99999999
Guarantor Name	SAMPLE A. SAMPLE
<b>F</b> Primary Insurance	INSURECO
Secondary Insurance	NIGHT FLYER

Statement Date: 06/18/2004

999999999999 \$ 2,570.26

REMIT THIS PAYMENT STUB TO:

STANFORD HOSPITAL & CLINICS  
FILE 74431 PO BOX 60000  
SAN FRANCISCO, CA 94160



## This is the Hospital Account Statement

### Important Message

Thank you for selecting Stanford Hospital & Clinics.

This bill is a summarized statement of your hospital account at Stanford Hospital. A complete itemized statement for each account is available upon request.

Please note your physicians will bill separately for their professional services.

Page 1 of 2

### Questions

#### • Questions?

Call **(650) 498-7200** or **(800) 333-7491** to reach Customer Service during our regular business hours (Monday - Friday, 8:00 am to 5:00 pm) or our new Automated Voice Telephone System 24 hours a day, 7 days a week.

#### • Billing Office Location:

2690 Hanover Street in Palo Alto, CA.  
Hours are Monday-Friday from 9:00 am to 4:00 pm.

#### • Mail Payments To:

Stanford Hospital & Clinics  
File 74431 PO Box 60000  
San Francisco, CA 94160

#### • Make Checks or Money Orders Payable to:

Stanford Hospitals & Clinics

Patient Name	Medical Record	Date Due
SAMPLE A. SAMPLE	99999999	Upon Receipt
Amount Due		Amount I Am Paying
\$ 2,570.26		\$

Check here if your address or insurance information has changed. Please indicate changes on the back of this page.

**To pay by credit card:** For your convenience, you may pay by Visa, MasterCard, Discover, or American Express. Please indicate your credit card preference, provide the account information, and sign below.



Account No. \_\_\_\_\_

Expiration Date \_\_\_\_\_

Signature X \_\_\_\_\_

I authorize Stanford Hospital & Clinics to charge my credit card for the amount indicated.

SUMCD1S1-01

**Statement Date**

06/18/2004

**Account Number**

999999999999

Page 2 of 2

***Patient Services Provided - Itemized Charges***

**Summarized Detail of Stanford Hospital Account Number 999999999999**

A summarized detail of services and charges for each outstanding account due is provided below. A complete itemized statement for each account is available upon request. Please keep this page for further reference.

**Account Number:** 999999999999    **Service Date(s):** 04/17/1997    **Type of Service:** Outpatient

**A**

**D**

Payment is due upon receipt. Please enter the amount you are paying on the remittance stub, detach, and send with your check, money order, or credit card information in the enclosed reply envelope.

**Services and Charges**

LABORATORY.....	\$ 2,570.26
<b>Total Charges.....</b>	<b>\$ 2,570.26</b>

**Payments and Adjustments as of 06/18/2004**

Patient Payments.....	\$ 0.00
Insurance Payments.....	\$ 0.00
Insurance Adjustments.....	\$ 0.00
Other Adjustments*.....	\$ 0.00

**E**

**Amount You Owe for this Account.....\$ 2,570.26**

**B**

\*See Reverse of Page One for Additional Information

**Usted recibirá  
un estado de  
cada cuenta del  
hospital por  
separado en el  
caso de que  
el saldo corra a  
su cargo.**

# Estado de cuenta mensual del hospital – página 1

Clave de información importante incluida en su estado de cuenta

- A** - Número de Cuenta (Account Number)
- B** - Importe Pendiente de Pago (Amount Due from You)
- C** - Fecha de Límite de Pago (Date Payment is Due)
- D** - Fecha[s] de Servicio (Date[s] of Service)
- E** - Actividades de Pago y de Crédito (Payment and Credit Activity)
- F** - Información Sobre su Seguro Médico (Insurance Information)



Lucile Salter Packard  
Children's Hospital

STANFORD UNIVERSITY MEDICAL CENTER

Recibirá un estado de cuenta separado del Lucile Packard Children's Hospital y del Stanford Hospital & Clinics

SAMPLE A. SAMPLE  
123 MAIN ST.  
ANYTOWN, US 123451234

## This is the Hospital Monthly Statement

### Important Message

Thank you for selecting Stanford Hospital & Clinics.

This bill is a summarized statement of your hospital account(s) at Stanford Hospital. A complete itemized statement for each account is available upon request.

Please note your physicians will bill separately for their professional services.

Page 1 of 2

### Accounts Now Due as of Statement Date \*

Statement Date	07/13/2004
Account Number	Amount Due
999999999999	\$ 126.03
<b>C</b> Balance Due 07/27/2004	<b>\$ 126.03</b>

### Questions

#### • Questions?

Call **(650) 498-7200** or **(800) 333-7491** to reach Customer Service during our regular business hours (Monday - Friday, 8:00 am to 5:00 pm) or our new Automated Voice Telephone System 24 hours a day, 7 days a week.

#### • Billing Office Location:

2690 Hanover Street in Palo Alto, CA.  
Hours are Monday-Friday from 9:00 am to 4:00 pm.

#### • Mail Payments To:

Stanford Hospital & Clinics  
File 74431 PO Box 60000  
San Francisco, CA 94160

#### • Make Checks or Money Orders Payable to:

Stanford Hospitals & Clinics

### Insurance Information

Please confirm that the information is correct for:

Patient Name	SAMPLE A. SAMPLE
Medical Record No.	12345678
Guarantor Name	SAMPLE A. SAMPLE

Insurance information and payment activity on individual accounts are included in the attached detail.

Statement Date: 07/13/2004

999999999999	\$ 126.03
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Patient Name	Medical Record	Date Due
SAMPLE A. SAMPLE	12345678	07/27/2004
Amount Due	Amount I Am Paying	
\$ 126.03	\$	

REMIT THIS PAYMENT STUB TO:

STANFORD HOSPITAL & CLINICS  
FILE 74431 PO BOX 60000  
SAN FRANCISCO, CA 94160



Check here if your address or insurance information has changed. Please indicate changes on the back of this page.

**To pay by credit card:** For your convenience, you may pay by Visa, MasterCard, Discover, or American Express. Please indicate your credit card preference, provide the account information, and sign below.



Account No. \_\_\_\_\_

Expiration Date \_\_\_\_\_

Signature X \_\_\_\_\_

I authorize Stanford Hospital and Clinics to charge my credit card for the amount indicated.

SUMC01

# Estado de cuenta mensual del hospital – página 2

Statement Date  
07/13/2004  
Medical Record Number  
12345678  
Page 2 of 2

## Patient Services Provided - Itemized Charges

### Monthly Detail of Stanford Hospital Account(s) Due For **SAMPLE A. SAMPLE**

A summarized detail of services and charges for each outstanding account due is provided below. A complete itemized statement for each account is available upon request. Please keep this page for further reference.

**A** Account Number: 99999999999 **D** Service Date(s): 08/19/2002 - 08/19/2003 Type of Service: INPATIENT

**F** Primary Insurance: INSURECO  
Secondary Insurance:

**Account Activity Since Last Statement**

Previous Balance.....	\$ 126.03
New Charges/Charge Adjustments*.....	\$ 0.00
Patient Payments.....	\$ 0.00
Insurance Payments.....	\$ 0.00
Insurance Adjustments.....	\$ 0.00
Other Adjustments*.....	\$ 0.00

**B** Amount You Owe for this Account..... **E** \$ 126.03

**C**

Payment is due on or before 07/27/2004

\* See Reverse of Page One for Additional Information

El hospital le enviará un estado de cuenta mensual de todas las cuentas cuyo saldo actual corre a su cargo.

# Estado de cuenta del Médico – lado 1

Clave de información importante incluida en su estado de cuenta

- A** - Número de Cuenta (Account Number)
- B** - Importe Pendiente de Pago (Amount Due from You)
- C** - Fecha de Límite de Pago (Date Payment is Due)
- D** - Fecha[s] de Servicio (Date[s] of Service)
- E** - Actividades de Pago y de Crédito (Payment and Credit Activity)
- F** - Información Sobre su Seguro Médico (Insurance Information)



Professional Services Operations  
Physician Billing  
File 74432 PO Box 60000  
San Francisco, CA 94160-0001  
www.stanfordhospital.com

TAX ID: 77-0465765

1V00001 9999999

9999999  
SAMPLE A SAMPLE  
123 S MAIN ST  
ANYTOWN USA 12345-1234



### Account Summary

<b>A</b> Account Number	9999999	<b>E</b>
Patient Payments (Last 30 Days)	\$ 0.00	
Total Account Balance	\$ 560.46	
Charges Pending With Insurance	\$ 218.00	<b>B</b>
<b>Amount Due</b>	<b>\$ 342.46</b>	

### Insurance Information

Please confirm that information is correct.

#### PRIMARY

Insurance MEDICARE ASSIGNED 301  
Address \_\_\_\_\_  
City/State/ZIP \_\_\_\_\_  
Group/Plan \_\_\_\_\_

Our records show that you have one insurance plan.  
If you are covered by any other insurance plans, please contact a patient account representative.



Statement Date: 05/28/2004

Stanford University Medical Center

MAKE CHECKS PAYABLE TO:

STANFORD MEDICAL CENTER  
FILE 74432 PO BOX 60000  
SAN FRANCISCO, CA 94160-0001



### A New Billing Statement for You!

As a result of suggestions made to us by patients just like you, we have re-designed our statement to provide you with complete, easy-to-read information about your bill. Thank you for your suggestions and your continued support. We are committed to continuing our efforts to improve the quality of service that we provide for you!

**Statement Date**  
05/28/2004

### Your Physician Statement

Page 1 of 2

### About Your Statement

Thank you for choosing Stanford University Medical Center for your health care needs. This is a statement of your account for services provided by our physicians. Detailed information on each service rendered can be found on the following pages. The balances due for each service are added together to arrive at the total amount due from you.

**Please send payment in full for \$ 342.46 by 06/08/2004.** **C**

If you have any questions, please call us at 1-800-549-3720 or 1-650-498-5850. Our patient account representatives are available from 9:00 am to 12:30 pm & 1:30 pm to 4:00 pm. Monday-Friday, or use our Automated Voice Telephone System which is available 24-hours a day.

**NOTE: This is a statement for physician services ONLY. You may receive a separate bill for hospital services and/or clinic facility fees.**

Please See Reverse Side For Account Detail →

Patient Name	Account Number	Date Due
Sample A Sample	9999999	06/08/2004
Amount Due	Amount Enclosed	
\$ 342.46	\$	

Check here if your address or insurance information has changed. Please indicate changes on the back of this page.

**To pay by credit card:** For your convenience, you may pay by Visa, MasterCard, Discover, or American Express. Please indicate your credit card preference, provide the account information, and sign below.



Account No. \_\_\_\_\_

Expiration Date \_\_\_\_\_

Signature X \_\_\_\_\_

# Estado de cuenta del Médico – lado 2

Statement Date

05/28/2004

Account Number

9999999

## Patient Statement for Sample A Sample

A summary of services, charges, claims and payments is provided below.  
Please keep this page for further reference.

Page 2 of 2

## Summary of Services and Amounts Due

Invoice Number: 99999999

Provider: Jane Perkins, MD, Nephrology

Service Date: 01/25/2003 **D**

Location: Inpatient

Your insurance plan has responded with payment, adjustment and/or denial as indicated below. Payment for this balance (and other balances due) can be made by paying the full amount due as shown on the payment stub of this statement.

### Services and Charges

01/25/2003	99232	SUBSEQUENT HOSP. CARE	180.00
01/26/2003	99232	SUBSEQUENT HOSP. CARE	180.00
01/27/2003	90935	HEMODIALYSIS, SINGLE EVAL.	537.00
01/28/2003	90935	HEMODIALYSIS, SINGLE EVAL.	537.00
01/29/2003	90935	HEMODIALYSIS, SINGLE EVAL.	537.00
		<b>Total Charges</b>	<b>\$ 1971.00</b>

### Claims and Payment Activity **E**

04/11/2003	Insurance Claim Filed	
06/13/2003	Insurance Payment	
	Payment	0.00
	Adjustment	0.00
08/28/2003	Insurance Payment	
	Payment	-383.49
	Adjustment	-1227.51
08/28/2003	Insurance Payment	
	Payment	0.00
	Adjustment	0.00
01/14/2004	Medicare Claim Filed	
01/29/2004	Medicare Payment	
	Payment	-17.54
	Note: Applied to Deductible	

Amount Now Due For This Service \$ 342.46

ICD9: 585

Referring Physician: Ronald Smith, MD

Usted recibirá  
una descripción  
de tallada a cerca  
de cada uno  
de los servicios  
que te ofrecen  
todos nuestros  
doctores.

## Change of Patient/Guarantor Information

New Address	City	State	Zip Code	New Phone #
Is this your Primary or Secondary insurance ? (Circle one)				
PRIMARY		SECONDARY		
Policy Holder (as it appears on the insurance card)	Policy/Identification #	Group #	Date of Birth	Coverage Effective Date
Group Name or Policy Holder's Employer/Union		Insurance Company Name		
Insurance Company Claim Address		Insurance Company Phone Number		