

Hospital Monthly Statement – page 1

Key to important information on your statement:

- A** - Account Number
- B** - Amount Due from You
- C** - Date Payment is Due
- D** - Date(s) of Service
- E** - Payment and Credit Activity
- F** - Insurance Information



Lucile Salter Packard
Children's Hospital

STANFORD UNIVERSITY MEDICAL CENTER

You will receive separate statements from Lucile Packard Children's Hospital and 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.

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Accounts Now Due as of Statement Date *

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

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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REMIT THIS PAYMENT STUB TO:

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



Patient Name	Medical Record	Date Due
SAMPLE A. SAMPLE	12345678	07/27/2004

Amount Due	Amount I Am Paying
\$ 126.03	\$

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

Statement Date
07/13/2004
Medical Record Number
12345678
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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.

Account Number: 999999999999 **Service Date(s): 08/19/2002 - 08/19/2003** **Type of Service: INPATIENT**

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

Amount You Owe for this Account..... \$ 126.03

Payment is due on or before 07/27/2004

* See Reverse of Page One for Additional Information

The hospital will send you a monthly summarized statement for all of the hospital accounts that have a current balance that is your responsibility.