NORTHERN WESTCHESTER HOSPITAL
400 E. Main St.
Mount Kisco
New York 10549

31596-U766

1 Patient Name		
JOHN Q PATIENT		
2 Service Date(s) From Through	3 Statement Date	Page
08/19/13 - 08/19/13	10/14/13	1

0101

5 If paying by CREDIT CARD, please complete this section

☐ MASTERCARD ☐ DISCOVER ☐ VISA ☐ AMERICAN EXPRESS

Card # ______________________

Exp. Date ________ / ________ AMT Authorized $ ________ . ____

Signature

4 This is the current insurance information on file

Please review and make corrections on the back of this form

	Insurance Name	Policy #
1.	CIGNA HEALTHCAR	
2.		
3.		

6 CHECK/M.O.

AMOUNT ENCLOSED

$ ________ . ____

000000 (PC1)

7

JOHN Q PATIENT
1234 MAIN ST
ANYTOWN, USA 12345-6789

8

NORTHERN WESTCHESTER HOSPITAL
PATIENT ACCOUNTS DEPARTMENT
400 EAST MAIN STREET
MT. KISCO, NY 10549-3417

9 Account Number	10 Previous Balance	11 Charges	12 Est. Ins Coverage	13 Payments/Adj's	14 AMT DUE From Patient
FN0005095080	0.00	252.00	0.00	-64.13	187.87

To ensure proper credit to your account, detach top section and return with your payment.

15 Account Number	16 Patient Name	17 Service Date(s)	18 Statement Dt	Page
FN0005432101	JOHN Q PATIENT	08/19/13 - 08/19/13	10/14/13	1

19 Date(s)	20 Description	21 Charges	22 Est. Ins Coverage	23 Payments/Adj's
08/19/13	NEG PRESSURE WD CARE <=50SQCM	252.00		
08/27/13	ADJ CIGNA HEALTHCARE POS			-80.64
09/10/13	PMT CIGNA HEALTHCARE POS; RCP DCN:8681324007954			0.00
09/12/13	NYS SURCHARGE 9.63			16.51
	Estimated insurance due:		0.00	
24 Previous Balance: 0.00	Column Totals:	252.00	0.00	-64.13

Account Balance	187.87
Statement Due Date	10/29/13
Agreement Amount	
25 **Amount Due from Patient:**	187.87

Pay online: www.nwhc.net/paymybill

Thank you for selecting Northern Westchester for your care

This statement represents Hospital charges only. You will be billed separately for physician services.

HOW CAN WE HELP?

Financial Assistance Programs, please call **(914) 666-1512.** Financial Counselors can determine if you are eligible for assistance programs including payment arrangements.

Billing Inquiries or Pay By Phone, please call **(914) 666-1701.** Patient Account Representatives are available 9am to 5pm, Monday through Friday.

NORTHERN WESTCHESTER HOSPITAL
400 E. Main St.
Mount Kisco
New York 10549

See reverse side for explanation of statement

31596-U766*TWI0JV5FN000001

Use this space to make corrections or additions to insurance information. Please include a photocopy of your insurance card.

Medicare # ______________________________

For other insurance, please check one and complete the area below.

☐ Blue Cross ☐ Blue Shield ☐ Commercial

☐ HMO ☐ Worker's Comp./No-fault ☐ Other

Insurance Co. Name ______________________________

Address ______________________________

City/State/Zip ______________________________

Policy # ______________ Group # ______________

Policy Holder ______________________________

Relationship to Patient ______________________________

Employer Name ______________________________

New York Medicaid # ______________________________

For other insurance, please check one and complete the area below.

☐ Blue Cross ☐ Blue Shield ☐ Commercial

☐ HMO ☐ Worker's Comp./No-fault ☐ Other

Insurance Co. Name ______________________________

Address ______________________________

City/State/Zip ______________________________

Policy # ______________ Group # ______________

Policy Holder ______________________________

Relationship to Patient ______________________________

Employer Name ______________________________

Explanation of Statement of Account

1 & 16 Patient Name: Person who received services.

2 & 17 Service Date(s) - From/Through: Period of time in which services were provided; admission through discharge for inpatient stays or beginning and ending date(s) for outpatient services.

3 & 18 Statement Date; Date on which this form was produced. Statement includes all transactions posted on or before this date.

4 Insurance information on file (#1-4): Names of insurance companies and policy numbers on file with the billing office.

5 If paying by CREDIT CARD, please complete this section:

Card #:	Enter credit card account number.
Exp. Date:	Enter date on which card expires.
Amt Authorized:	Enter amount approved for payment by card holder.
Signature:	Signature of card holder.

6 CHECK/M.O.: Enter amount being paid by check or money order.

7 Responsible Party: Name/mailing address of the person responsible for payment.

8 Payment mailing address: When placing top section of statement in return envelope, be sure that this address is visible in the window.

9 & 15 Account Number: Number used to identify the account.

10 & 24 Previous Balance: Amount owed on this account as of the last statement.

11 & 21 Charges: Charges incurred on the account since the last statement.

12 & 22 Estimated Insurance Coverage: Amount of payment expected from insurance carrier(s) but not yet received. (Note: coverage cannot be estimated for some insurance carriers.)

13 & 23 Payments/Adjustments: Total of 1) payments by insurance and/or responsible party and 2) adjustments (such as credits, allowances or discounts) made to the account since the last statement.

14 & 25 Amount Due from Patient: Amount currently due for the patient/responsible party.