STATEMENT OF ACCOUNT

STATEMENT DATE	ACCOUNT NUMBER
6/30/14	GUARANTOR

McPherson Hospital
1000 Hospital Drive
McPherson, Ks 67460-2369

RETURN SERVICE REQUESTED

574-946-2125

0101

IF PAYING BY MASTERCARD OR VISA, SEE REVERSE FOR CREDIT CARD INFORMATION.

AMOUNT PAID

PAYMENTS AND CHARGES RECEIVED AFTER DATE OF THIS STATEMENT WILL BE REFLECTED ON THE NEXT STATEMENT.
☐ Please check box if above address is incorrect or insurance information has changed and indicate change(s) on reverse side.

656400 (PC1)

GUARANTOR NAME AND ADDRESS

JANE SMITH
6600 WALL STREET
MOBILE, AL 36695-0000

McPherson Hospital
1000 Hospital Drive
McPherson, Ks 67460-2369

TO INSURE PROPER CREDIT TO YOUR ACCOUNT, PLEASE RETURN THIS STUB WITH YOUR PAYMENT.

DATE	PATIENT ADMISSION NO./DESCRIPTION	CHARGES	PAYMENTS	INSURANCE PENDING	PATIENT PAY (YOU OWE)
4/02/14	Account: 000304 EXIST PA				
	SMITH JANE				
	Total Charges	86.80			
	Accum. Insurance Pmnts		51.80		
	Balance Due				35.00
4/23/14	Account: 000312 EXIST PA				
	SMITH JANE				
	Total Charges	104.20			
	Accum. Insurance Pmnts		69.20		
	Balance Due				35.00
3/14/14	Account: 000296 EXIST PA				
	SMITH JANE				
	Total Charges	104.20			
	Accum. Insurance Pmnts		34.88		
	Balance Due				69.32
3/05/14	Account: 000294 NEW PATI				
	SMITH JANE				
	Total Charges	121.60			
	Accum. Patient Payments		35.00		
	Accum. Insurance Pmnts		51.07		
	Balance Due				35.53

ACCOUNT BALANCE

TOTAL	INSURANCE PENDING	AMOUNT DUE NOW
174.85	.00	174.85

ACCOUNT NUMBER	STATEMENT DATE	PRINT DATE

HOSPITAL NAME
McPherson Hospital

8488

2306-CPSISTMT-147255-79544513-S; 256336-1-12; 35288794-1; 1

I WOULD LIKE TO PAY THE AMOUNT OF $ _____ USING THE FOLLOWING CREDIT CARD.

MasterCard ☐ VISA ☐ OTHER ☐ EXPIRATION DATE ☐☐☐☐ ZIP CODE ☐☐☐☐☐

CARDHOLDER SIGNATURE X _____ CARD NUMBER ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ AUTH. # ☐☐☐☐

***PLEASE CHECK WITH FACILITY ON ACCEPTING CARDS OTHER THAN VISA AND MASTERCARD.**

FOR OFFICE USE ONLY

_____ AUTHORIZATION NUMBER

_____ RECEIVED BY

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME TELEPHONE

EMPLOYER'S ADDRESS CITY STATE ZIP

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME

PRIMARY INSURANCE COMPANY'S ADDRESS

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME

SECONDARY INSURANCE COMPANY'S ADDRESS

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER