

AMITA HEALTH[®] Introducing your new statement

At AMITA Health we continually strive to improve services to our patients. We recently transitioned to a new billing system and statement. Depending on the date of your services at AMITA Health, you may receive more than one billing statement for a period of time.

Note: if you have an existing payment plan, you will need to set up a new payment plan for any current services you receive.

AMITA HEALTH[®]

1 Guarantor Name	2 Account Number	3 Statement Date	PAYMENT DUE
PAUL PATIENT	DC123456789	11/22/2020	4 83.14

Dear Paul Patient,

Thank you for choosing **AMITA Health** as your healthcare provider and for your prompt attention to this bill. Payment is due on **12/20/20**. Payment options are listed below.

5 You may pay your bill in full with a check or credit card in one of our ways:

- Pay online at www.emergetechnology.net/#/AMITA-Health-Hospital-Bill/
- To pay by phone dial **(833) 272-7581**
- Mail payment using the coupon below in the envelope provided.
- Pay in person at any of our locations

6 **Enroll in Electronic Billing today!**
To pay bill quickly and securely go to:
www.emergetechnology.net/#/AMITA-Health-Hospital-Bill/

7 **FINANCIAL ASSISTANCE** AMITA Health offers a Financial Assistance program to those who qualify. Applications and Financial Assistance Policy copies are available free of charge by calling **833-272-7581** or by visiting our website at <http://www.presencehealth.org/financial-assistance-documents>.

8 **BILLING QUESTIONS OR CONCERNS?** Please contact us at:
Phone: **(833) 272-7581**
Hours: **Mon-Fri: 8:00am - 4:30pm CST**

9 **Pay online at** www.emergetechnology.net/#/AMITA-Health-Hospital-Bill/

10 **Show Amount Paid Here** - Write the amount you are paying toward this bill.

11 **Make Checks Payable and Send To** - The provider name and address where payments should be sent.

12 **Change of Information** - Check this box to provide an updated address or insurance information. See the reverse side of the bottom portion of your statement to provide the detail of any updates.

AMITA HEALTH[®]
PO BOX 1259, Dept 149882
Oaks, PA 19456


PAUL PATIENT
1234 ANY STREET
ANYTOWN, USA 12345-6789

AMITA HEALTH
P.O. BOX 12345
OAKS, PA 00000-0000

scanline added here if needed

- 1 Name** - Name of person who is responsible for the bill.
- 2 Account/Guarantor Number** - The Account/Guarantor Number assigned to the person responsible for the bill.
- 3 Statement Date** - Date of your statement. If you have any questions, call customer service toll free at 833-272-7581.
- 4 Payment Due** - The amount owed that reflects total charges minus any payment you and/or your insurance company made and was posted to your account as of the statement date. Any payments made after your statement date will not be reflected in the current balance due.
- 5 Payment Options** - These are the payment options that are available to you.
- 6 iBoard** - Payment options that are available to you.
- 7 Pay Online** - This is the website to make your electronic payment.
- 8 Credit card payment** - If you are paying by credit card, use this area to fill in the type of credit card, card number, signature code (also known as a security code), amount you are paying, signature, and expiration date. We accept Mastercard, Discover, Visa, and American Express.
- 9 Due Date** - The date payment is due. If you are unable to pay in full by this date, call customer service toll free at 833-272-7581 for payment options.
- 10 Show Amount Paid Here** - Write the amount you are paying toward this bill.
- 11 Make Checks Payable and Send To** - The provider name and address where payments should be sent.
- 12 Change of Information** - Check this box to provide an updated address or insurance information. See the reverse side of the bottom portion of your statement to provide the detail of any updates.

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Guarantor Name	Account Number	Statement Date	PAYMENT DUE
PAUL PATIENT	DC123456789	11/22/2020	

13

Total Charges	\$2124.00
Insurance Payments	-\$1240.86
Insurance Adjustments	\$0.00
Your Current Balance	\$883.14

PATIENT NAME	ACCOUNT NUMBER	PRIMARY/SECONDARY INSURANCE	DATE OF SERVICE	LOCATION	SUMMARY	AMOUNT
15 HOSPITAL						
INOZA	DC01874539	LIABILITY/MED	10/20/2020	Plainfield	CERVICAL SPINE A P & LATERAL	\$818.00
		PAY/MVA		Imaging Center	THORACIC SPINE A P & LAT	\$621.00
		CIGNA PPO/			SHOULDER LEFT - 2 VIEWS	\$685.00
		POS/OA				
		Illinois Medicaid				
					TOTAL CHARGES	\$2124.00
					TOTAL PAYMENTS	-\$1240.86
					TOTAL ADJUSTMENTS	\$0.00
					PAYMENT DUE	\$883.14
					TOTAL PAYMENT DUE: \$883.14	

BILLING QUESTIONS OR CONCERNS?
Please contact us at:
Phone: **833-272-7581**
Hours: **Mon-Fri: 8:00am - 4:30pm CST**

17 You may receive bills from other providers.
Please contact them directly.

IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

18 PATIENT INFORMATION	19 INSURANCE INFORMATION																																																															
<table border="1" style="border-collapse: collapse; width: 100%;"> <tr><td colspan="2">Your Name (Last, First, Middle Initial)</td><td>Date of Birth</td></tr> <tr><td colspan="3">Address</td></tr> <tr><td>City</td><td>State</td><td>Zip</td></tr> <tr><td colspan="3">Telephone ()</td></tr> <tr><td colspan="3">Social Security #</td></tr> <tr><td>Employer's Name</td><td colspan="2">Telephone ()</td></tr> <tr><td colspan="3">Employer's Address</td></tr> <tr><td>City</td><td>State</td><td>Zip</td></tr> <tr><td colspan="3">Please Indicate If Applicable:</td></tr> <tr><td colspan="3"><input type="checkbox"/> AUTO ACCIDENT</td></tr> <tr><td colspan="3"><input type="checkbox"/> WORKER'S COMPENSATION</td></tr> </table>	Your Name (Last, First, Middle Initial)		Date of Birth	Address			City	State	Zip	Telephone ()			Social Security #			Employer's Name	Telephone ()		Employer's Address			City	State	Zip	Please Indicate If Applicable:			<input type="checkbox"/> AUTO ACCIDENT			<input type="checkbox"/> WORKER'S COMPENSATION			<table border="1" style="border-collapse: collapse; width: 100%;"> <tr><td colspan="3">Primary Insurance Company Name</td></tr> <tr><td colspan="3">Address</td></tr> <tr><td>City</td><td>State</td><td>Zip</td></tr> <tr><td colspan="3">Telephone ()</td></tr> <tr><td>Policy Number</td><td colspan="2">Group Number</td></tr> <tr><td colspan="3">Secondary Insurance Company Name</td></tr> <tr><td colspan="3">Address</td></tr> <tr><td>City</td><td>State</td><td>Zip</td></tr> <tr><td colspan="3">Telephone ()</td></tr> <tr><td>Policy Number</td><td colspan="2">Group Number</td></tr> </table>	Primary Insurance Company Name			Address			City	State	Zip	Telephone ()			Policy Number	Group Number		Secondary Insurance Company Name			Address			City	State	Zip	Telephone ()			Policy Number	Group Number	
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- 13 Summary** - This shows your balance due from prior statements, payments you've made, any new charges since your last statement, and your current balance due.
- 14 Detail Column Header** - Detail information.
- 15 Service Description** - Information specific to your visit, including: date of service, patient name, visit type, account number, primary insurance, and secondary insurance.
- 16 Amount Due** - Total amount due for a specific date of service.
- 17 Total Payment Due** - The total for services at all locations and all dates of service. This amount reflects any payments made and posted to your account to date. Any payments made after your Statement Date will not be reflected in the current balance due.
- 18 Patient Updates** - Enter any updated or corrected information. In addition, please be sure to check the box on the front of the statement.
- 19 Insurance Updates** - Enter any updated or corrected information. Be sure to check the box on the front of the statement.

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Questions?

Please contact customer service toll free at 833-272-7581.

Hours: Mon - Fri 8:00am - 4:30pm CST

Payments can be made online at <https://www.emergetechnology.net/#/AMITA-Health-Hospital-Bill/>