

### Understanding Your Patient Detail Hospital Bill

You will receive this detailed statement if you do not have any medical insurance coverage (self-pay) or if there is a self pay balance after your insurance carrier(s) has paid applicable charges. This is an itemized list of hospital charges only. You may receive separate bill(s) for physician services and other professional services such as those provided by a radiologist, pathologist, anesthesiologist, etc.

**1** **Statement Date:** 01/20/2006<sup>a</sup>    **Due Date:** 02/20/2006<sup>b</sup>    **Total Amount Due:** **\$200.00**<sup>c</sup>  
**Guarantor:** Doe, John<sup>d</sup>    **Guarantor No.** 1234567<sup>e</sup>    **Total Self Pay Balance:** **\$200.00**<sup>f</sup>

<b>2</b> <b>3</b> <b>4</b> <b>5</b> <b>6</b> PATIENT DETAIL HOSPITAL BILL (PG 1 of 1)				
Patient Name	Hospital Account Number	Service Date	Summary	Amount
Doe, John	12345671231	1/1/06-1/3/06	Total Hospital Charges <sup>a</sup>	\$ 1,000.00
		1/1/2006	OUTPATIENT VENIPUNCTURE (3001006) <sup>b</sup>	\$ 300.00
		1/2/2006	FLECANIDE (3181085)	\$ 300.00
		1/3/2006	ELECTROCARDIOGRAM (6383019)	\$ 400.00
			Sub-Total :	\$ 1,000.00
			Insurance Payments/Adjustments <sup>c</sup>	\$ (800.00)
			Patient Discounts	\$ -
			Patient Payments	\$ -
			AMOUNT DUE <sup>d</sup>	<b>\$ 200.00</b>
			<b>TOTAL AMOUNT DUE BY</b> : 02/20/06 <sup>e</sup>	<b>\$ 200.00</b>

**7** For hospital account questions or information, please call customer service department at 312-942-5693 or toll free at 866-761-7812 Monday through Friday 8am-4:30pm or email us at [www.billing\\_info@rush.edu](mailto:www.billing_info@rush.edu). Rush University Medical Center offers a number of Financial Assistance Programs and/or monthly time payments. For further information, please contact a customer service representative at the number listed above or visit our website at [www.rush.edu](http://www.rush.edu)

**For online hospital bill payment visit Rush University Medical Center website at [www.rush.edu](http://www.rush.edu)**

**8** Guarantor Number     **9** Guarantor Name     **10** Amount Due     **11** Payment Amount

**12** **To pay by mail:**  
Make check or money order payable to Rush University Medical Center. Include your account number on your check and use the enclosed self addressed envelope.

**13** **To pay by credit card:**  
Please indicate credit card preference, provide account information and sign below.

REMIT THIS STUB TO:

Rush University Medical Center P.O. Box 4075 Carol Stream, IL 60197-4075	Account No _____ Card Holder Name _____ Signature X _____ Exp. Date _____ Verification Code _____
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## Understanding Your Patient Detail Hospital Bill - Descriptions

<p><b>1. Header Row</b> This section contains standard information about the amount owed and the person responsible for payment (see 1a-1f).</p>	<p><b>6. Amount</b> The amount in this section refers to the dollar amount for each summary item (e.g., charges, payments, adjustments, etc)</p>
<p><b>1a.</b> STATEMENT DATE is date bill was created  <b>1b.</b> DUE DATE is date payment is due  <b>1c.</b> TOTAL AMOUNT DUE is amount guarantor is expected to pay before the indicated due date  <b>1d.</b> GUARANTOR is person responsible for payment  <b>1e.</b> GUARANTOR NO. is ID assigned to guarantor by the hospital  <b>1f.</b> TOTAL SELF PAY BALANCE is the total self pay balance of this specific hospital visit. This balance excludes any outstanding physician charges you may owe for professional services (i.e., radiology, labs, anesthesiology, etc)</p>	<p><b>7. Informational Memo 1</b> This is an itemized list of hospital charges only. You may receive a separate bill for outstanding physician balances you may owe for profession services such as radiology, labs, anesthesiology, etc).</p> <p><b>Informational Memo 2</b> This section contains customer service, financial assistance, and contact information.</p>
<p><b>2. Patient Name</b> The patient name is the name of the person receiving services. This name should match the legal name that appears on acceptable forms of identification.</p>	<p><b>8-9. Guarantor Number &amp; Guarantor Name</b> A guarantor is ultimately responsible for outstanding balances. The guarantor may or may not be the patient. For example, a parents can be the guarantor for his/her child. The guarantor name is verified during registration. The guarantor number is assigned by the hospital during registration.</p>
<p><b>3. Hospital Account Number</b> The unique internal number assigned by the hospital for a specific hospital visit.</p>	<p><b>10. Amount Due</b> The amount due is the amount you are expected to pay the hospital. This amount may include coinsurance/deductible if self-pay after insurance.</p>
<p><b>4. Service Date</b> The date(s) medical services were rendered; the admit through discharge date(s).</p>	<p><b>11. Payment Amount</b> The payment amount you choose to pay. This amount should match the amount due whenever possible.</p>
<p><b>5. Summary</b> This section contains standard information related to your medical services (see 5a-5e.).</p>	<p><b>12. To pay by mail</b> This section contains the hospital payment name and address that you will use if you choose to make your payment to the hospital using a check or money order.</p>
<p><b>5a.</b> Total Hospital Charges for specified service dates  <b>5b.</b> Charge description and ('hospital internal charge code')  <b>5c.</b> Insurance Payments/Adjustments ('insurance payer name'), Patient Discounts, and/or Patient Payments posted prior to statement date  <b>5d.</b> Amount Due from the guarantor  <b>5e.</b> Total Amount Due By MM/DD/YY including any approved payment plan terms</p>	<p><b>13. To pay by credit card</b> Complete this section if you choose to make your payment to the hospital using an American Express, MasterCard, Visa, or Discover credit card. The Verification Code is the three (3) digit code located on the back of your credit card.</p>

Note, sections 1-7 refers to the bill and sections 8-13 refers to the payment coupon attached to the bottom of the bill.