

Understanding your Wheaton Franciscan Healthcare Statement

1. **Facility Name** – The hospital name appears here.
2. **Your Statement** – Read this area for important information and notices regarding your account.
3. **Summary of Charges** – Major service category or location of service and related charge.
4. **Total Charges** – Total amount billed for this account.
5. **Account Number** – The unique number assigned to the visit for which you are being billed on this statement.
6. **Patient Name** – Name of the person who received service.
7. **Statement Date** – Date your statement was created. Any payments or adjustments posted after this date will not be reflected in the current balance due.
8. **Date of Service** – Date(s) of service for this account.
9. **Total Charges** – Total amount billed for this account.
10. **Payments/Adjustments Received** – Total payments received from your insurance company, patient and preferred insurance discount for which you qualify.
11. **Primary Insurance Name** – The name of the primary insurance we have listed and billed.
12. **Secondary Insurance Name** – The name of any secondary insurance we have listed and billed.
13. **Questions** – Patient Business Office Customer Service contact phone numbers and email address.
14. **This is your balance** – The amount owed that reflects the total charges less any payment you and/or your insurance company as of the statement date. Any payments paid after your statement date will not be reflected in the current balance due.
15. **Facility Name** – The hospital name and payment address
16. **Credit Card Payment** – If paying by credit card, use this area to complete the necessary information, including type of credit card, card number, expiration date, amount you are paying, and signature. We accept American Express, Discover, MasterCard and Visa.
17. **Due Date** – Date payment is due. If unable to pay in full by this date call Customer Service for payment options
18. **Statement Date** – Date your statement was created. Any payments posted after this date will not be reflected in the current Amount Due.
19. **Acct #** - Account number which is the unique number assigned to the visit for which you are being billed on this statement.
20. **Amount Due** – The amount owed that reflects the total charges less any payment you and/or your insurance company as of the statement date. Any payments paid after your statement date will not be reflected in the current balance due.
21. **Show Amount Paid Here** – Write the amount you are paying toward this bill.
22. **Addressee** – The guarantor name and address appears here.
23. **Remit To** – the hospital name and payment address is listed here.
24. **Business Office Service/Payment Options** – General Information
25. **Physician Fees** – General Information
26. **Change of Address** – Enter any updated or corrected information. In addition, be sure to check the box on the front of the statement.
27. **Change of Insurance Information** – Enter any updated or corrected information.



Wheaton Franciscan Healthcare

In Partnership with the Felician Sisters



2 Dear (Patient Name), Thank you for choosing our facility for health care needs. The amount due referenced in this statement is your responsibility; please make payment in full by due date. If you are unable to pay in full, please call our office to make monthly payment arrangements. If you have insurance and it is not listed in the lower right hand corner of this statement, please contact our office with your insurance information. If you have already mailed payment in full, please disregard this statement and accept our thanks for your prompt response.

SUMMARY OF CHARGES

Table with 2 columns: Description, Amount. Row 3: EMERGENCY DEPT 445.25. Row 4: Total Charges \$445.25

ACCOUNT SUMMARY

Table with 2 columns: Description, Amount. Row 5: Account Number xxxxxx. Row 6: Patient Name. Row 7: Statement Date 07/07/06. Row 8: Date of Service 05/30/06. Row 9: Total Charges \$445.25. Row 10: Payments/Adjustments Received -\$393.46

INSURANCE INFORMATION

Table with 2 columns: Description, Value. Row 11: Primary Insurance Name UNITED HEALTHCARE. Row 12: Secondary Insurance Name None Listed

QUESTIONS

13 Billing questions or an itemized bill request? Call your customer service representative at 414-456-3000 (local) or 888-553-5009, Monday-Friday, 8:00 am to 5:00 pm. Questions concerning this statement can be emailed to wheatonbusinessoffice@wfhc.org. See back for more information.

Si tienes preguntas sobre tu cuenta porfavor ilama 414-456-3000 or 888-553-5009.

14 This is your balance \$51.79

PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

Check box if address below is incorrect and indicate change(s) on reverse side.



15 ST. JOSEPH BOX 68-9510 MILWAUKEE, WI 53268-9510

33880-93AN

RETURN SERVICE REQUESTED

Page: 1 Please write your account number on your check.

ADDRESSEE:

Payment form with fields for card type (Mastercard, Discover, Visa, American Express), card number, signature, due date (07/28/2006), statement date (07/07/2006), amount due (\$51.79), and account number (xxxxxxx).

652864

REMIT TO:

22 ANYONE J. PATIENT 1234 MAIN STREET MILWAUKEE, WISCONSIN 11111

23 ST. JOSEPH BOX 68-9510 MILWAUKEE, WI 53268-9510

Thank you for choosing a Wheaton Franciscan Healthcare facility for your health care needs. The following information is provided to explain the Wheaton Franciscan Healthcare billing process.

Please visit our website for answers to frequently asked questions (FAQs) at www.wfhc.org

24 Health Insurance: You are responsible for providing accurate insurance information as well as reporting any insurance coverage changes to our billing office. We will bill your insurance company before requiring full payment from you. Co-payments, deductibles and co-insurance may be collected at the time of your service. It is your responsibility to ensure that your bill is paid in a timely manner either by your insurance company or by you.

Medicare: Wheaton Franciscan Healthcare facilities accept Medicare assignment. Payment will be made directly to the Wheaton facility providing your services. You are responsible for your deductible and co-insurance. If you have a secondary insurance, we will bill the secondary insurance on your behalf.

Payment Options: It is Wheaton Franciscan Healthcare’s policy that if your account balance was not paid at the time of service, it needs to be paid in full by the due date listed on this statement. It’s important to know that making partial payments without establishing a formal interest-free payment agreement with us will not keep your account in good standing. If you are unable to pay your full balance by the due date, please call Customer Service to establish an acceptable payment plan.

If you are a self-paying patient or have a personal financial situation that may require special payment arrangements, you are eligible to be considered for a discount under our discounting guidelines or our financial assistance program called Community Care. For more information please call Customer Service at the phone number listed on the front of this statement.

If you have been a patient multiple times, you may receive separate statements for each visit. If you have questions concerning your bill or would like an itemized statement please call Customer Service at the phone number listed on the front of this statement.

25 Physician Fees: Wheaton Franciscan Healthcare facility charges do not include physician fees. You will receive separate billings from physicians, such as radiologists, anesthesiologists, pathologists, and Emergency and Urgent Care department physicians who treated you. If you have questions regarding those charges, please call the physician billing office listed on their statement.

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE . . .

ABOUT YOU:

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YOUR NAME (Last, First, Middle Initial)			
ADDRESS			
CITY	STATE	ZIP	
TELEPHONE	MARITAL STATUS	<input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
EMPLOYER'S NAME		TELEPHONE	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP

ABOUT YOUR INSURANCE:

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YOUR PRIMARY INSURANCE COMPANY'S NAME		EFFECTIVE DATE
PRIMARY INSURANCE COMPANY'S ADDRESS		TELEPHONE
CITY	STATE	ZIP
POLICYHOLDER'S ID NUMBER	GROUP PLAN NUMBER	
YOUR SECONDARY INSURANCE COMPANY'S NAME		EFFECTIVE DATE
SECONDARY INSURANCE COMPANY'S ADDRESS		TELEPHONE
CITY	STATE	ZIP
POLICYHOLDER'S ID NUMBER	GROUP PLAN NUMBER	

