

PATIENT ACCOUNT STATEMENT



PO BOX 42008 Phoenix, AZ 85080-2008

Billing Questions? Please call:
 Local: (931) 815-4240
 Toll Free: 1-877-348-7082

All notices and correspondence must be directed to:
 300 20th Ave, Suite 402, Nashville, TN 37203

If paying by one of these credit cards, please enter the information on the reverse side.

STATEMENT DATE 07/28/2020	ACCOUNT NUMBER [REDACTED]	PLEASE PAY NOW \$948.50	
DUE UPON RECEIPT		Indicate Amount Paid \$	

413-24

[REDACTED]
 [REDACTED]
 [REDACTED]
 MORFREESBORO, TN 37128-1208

MAKE CHECKS PAYABLE AND REMIT TO:

ST. THOMAS STONES RIVER HOSPITAL
 PO BOX 741756
 ATLANTA, GA 30374-1756



Check box if address or insurance information is incorrect and indicate changes on reverse side.

Please detach and remit top portion with payment.

ACCOUNT NUMBER [REDACTED]	STATEMENT DATE 07/28/2020	DUE DATE UPON RECEIPT
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DATE	DESCRIPTION	TRANSACTIONS
SERVICES FOR ROBERT E MITCHELL		
05/30/2020	EMERG RM	2,064.50
05/30/2020	LABORATORY	328.20
05/30/2020	XRAY	402.45
PAYMENTS AND ADJUSTMENTS		
06/17/2020	BC OTHER PYMT	-991.00
	TOTAL INSURANCE DISCOUNTS	-730.65
	TOTAL PATIENT PAYMENTS	-125.00
MOST RECENT PATIENT PAYMENTS		
07/10/2020	PATIENT PAYMENT	-125.00

ACCOUNT BALANCE \$948.50

An easier, more convenient way to pay

You can now pay your Saint Thomas Stones River Hospital bill online at ascension.org/hospitalbill

- Make payments in minutes
- View your current bill and payment history
- Manage Hospital bills for your whole family, all in one place

Billed amounts for services do not include charges for healthcare providers who are not employed by the healthcare facility, including anesthesiologists, emergency physicians, pathologists, and radiologists.

Recently we notified you that your insurance company had processed the above referenced account. We advised the balance remaining was your responsibility and requested payment in full. As of the date of this statement, we have not received your payment.

Please avoid collection action by remitting payment in full today. We will allow thirty days from the date of this statement to receive payment in full or to establish payment arrangements.

Saint Thomas Health, in accordance with our mission and core values, offers a Financial Assistance program available to all patients, both with insurance and without insurance. Patients may apply for Financial Assistance at any time. Applications and Financial Assistance policy copies are available free of charge by calling (931) 815-4240 or 1-877-348-7082 or by visiting our website at <http://healthcare.ascension.org/Financial-Assistance>, or you may write us requesting an application by mail at Saint Thomas Health attention Financial Assistance, PO Box 380, Nashville, TN, 37202.

If payment in full was sent prior to the date of this statement, please disregard and accept our sincere thank you.

INSURANCE ON FILE BCBS FEDERAL EMPLOYE	GROUP 112	POLICY [REDACTED]
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\$948.50



**BlueCross.
BlueShield.**

Federal Employee Program.

**Explanation of Benefits
THIS IS NOT A BILL**

BLUECROSS & BLUESHIELD OF TENNESSEE
FEP CLAIMS DEPARTMENT
1 CAMERON HILL CIRCLE
CHATTANOOGA, TN 37402
CHATTANOOGA PHONE NUMBER 423-535-5707
TOLL FREE 1-800-572-1003



007625



EXPLANATION OF BENEFITS AT A GLANCE	
We Sent Check To:	PROVIDER OF SERVICE
Patient Name:	[REDACTED]
Dates of Service:	05/30/2020 - 05/30/2020
You Owe the Provider:	\$125.00

ID Number: [REDACTED]
Claim Number: [REDACTED]
Claim Paid On: 06/17/2020
Claim Received On: 06/08/2020
Claim Processed On: 06/09/2020
Patient Acct No: [REDACTED]

Provider: Saint Thomas Stones River Hospital
Type: PREFERRED PROVIDER
Dates of Service: 05/30/2020 - 05/30/2020

Type of Service	Submitted Charges	Plan Allowance	Remark Codes	Deduct	Coinsurance Or Copay	Medicare/ Other Ins.	What We Paid	You Owe the Provider
DIAGNOSTIC LAB TEST	45.80		634					
DIAGNOSTIC LAB TEST	34.45		634					
DIAGNOSTIC LAB TEST	61.30		634					
DIAGNOSTIC LAB TEST	36.65		634					
DIAGNOSTIC LAB TEST	35.60		634					
DIAGNOSTIC LAB TEST	52.25		634					
DIAGNOSTIC LAB TEST	41.30		634					
DIAGNOSTIC LAB TEST	20.85		634					
XRAY, TECHNICAL CHRG	402.45		634					
MEDICAL CARE	2,064.50	1,116.00	610		125.00		991.00	125.00
TOTALS:	2,795.15	1,116.00		0.00	125.00	0.00	991.00	125.00

EXPLANATION OF REMARK CODES



610--THE SUBMITTED CHARGES EXCEED OUR ALLOWABLE CHARGES FOR THESE SERVICES. OUR ALLOWABLE CHARGES ARE THE SUBMITTED CHARGES LESS ANY NON-COVERED CHARGES. BECAUSE YOUR PROVIDER HAS A CONTRACTUAL AGREEMENT WITH YOUR PLAN, YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE SUBMITTED CHARGES AND OUR ALLOWABLE CHARGES.

634--BENEFITS FOR THESE SERVICES ARE INCLUDED IN OUR ALLOWABLE CHARGES FOR ANOTHER COVERED SERVICE PROVIDED ON THE SAME DATE OF SERVICE. ADDITIONAL BENEFITS ARE NOT AVAILABLE FOR THIS CHARGE. BECAUSE THIS PROVIDER HAS A CONTRACTUAL AGREEMENT WITH YOUR LOCAL PLAN, YOU ARE NOT RESPONSIBLE FOR THESE CHARGES.

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