

Stanford Hospital & Clinics
Lucile Packard Children's Hospital
Patient Financial Services
2690 Hanover Street
Palo Alto, CA 94304

8004

Understanding Your Billing Statement



**Stanford
Hospital & Clinics**

**Lucile Packard
Children's Hospital**



Lucile Salter Packard
Children's Hospital

STANFORD UNIVERSITY MEDICAL CENTER

Understanding Your Billing Statement

Stanford Hospital & Clinics and Lucile Packard Children's Hospital have designed this brochure to guide you through our billing statements and to bring key information to your attention.

The three statements explained in this brochure are:

Hospital Account Statement—A statement for an individual account based on the type of hospital service you received (i.e. inpatient stay, emergency room visit, outpatient surgery, monthly outpatient services)

Hospital Monthly Statement—A consolidated monthly statement summarizing the activity on all your outstanding individual hospital account(s)

Physician Statement—A statement for physicians' services provided to you at Stanford Hospital & Clinics and Lucile Packard Children's Hospital

Depending on the type of service(s) provided, you will receive separate statements from Stanford Hospital & Clinics, Lucile Packard Children's Hospital, and Stanford and Packard physicians (including radiologists, surgeons, anesthesiologists and other specialists) as well as other providers involved in your care.

We will bill your primary insurance and, if applicable, your secondary insurance carrier as a courtesy. It is important to remember that health insurance coverage varies and some services may not be covered. Co-payments, co-insurance, deductibles and non-covered services will be your responsibility according to your health insurance coverage.

Customer Service Contact Information

If you have any questions or comments about your billing statement(s), please contact the appropriate Customer Service Department:

Stanford Hospital & Clinics

www.stanfordhospital.com

Monday - Friday, 8:00 am - 5:00 pm
(800) 333-7491 or (650) 498-7200

Lucile Packard Children's Hospital

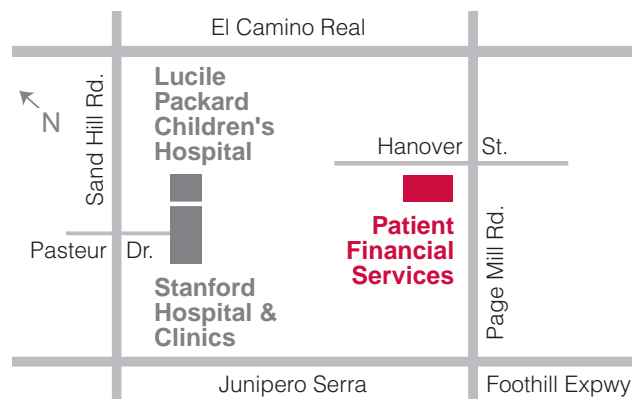
www.lpch.org

Monday - Friday, 8:00 am - 5:00 pm
(800) 308-3285 or (650) 473-3938

Physician Billing at Stanford and Packard

Monday - Friday, 9:00 am - 12:30 pm and
1:30 pm - 4:00 pm
(800) 549-3720 or (650) 498-5850

If you prefer to discuss your billing statement in person, you are welcome to meet with our customer service staff from 8:00 am - 4:00 pm, Monday through Friday. Patient Financial Services is located at 2690 Hanover Street in Palo Alto, CA.



Hospital Account Statement – page 1

Key to important information on your statement:

- A** - Account Number
- B** - Amount Due from You
- C** - Date Payment is Due
- D** - Date(s) of Service
- E** - Payment and Credit Activity
- F** - Insurance Information



Lucile Salter Packard
Children's Hospital

STANFORD UNIVERSITY MEDICAL CENTER

You will receive separate statements from Lucile Packard Children's Hospital and Stanford Hospital & Clinics.

SAMPLE A. SAMPLE
123 MAIN ST
ANYTOWN, XX 12345-1234

This is the Hospital Account Statement

Important Message

Thank you for selecting Stanford Hospital & Clinics.

This bill is a summarized statement of your hospital account at Stanford Hospital. A complete itemized statement for each account is available upon request.

Please note your physicians will bill separately for their professional services.

Page 1 of 2

Hospital Account Summary

Statement Date	06/18/2004
Service Date(s)	04/17/1997
A Account Number	999999999999
Total Charges	\$ 2,570.26
Patient Payments	\$ 0.00
Insurance Payments	\$ 0.00
Insurance Adjustments	\$ 0.00
Other Adjustments*	\$ 0.00
C Balance Due Upon Receipt	\$ 2,570.26

Insurance Information

Please confirm that the information is correct for:

Patient Name	SAMPLE A. SAMPLE
Medical Record No.	99999999
Guarantor Name	SAMPLE A. SAMPLE
F Primary Insurance	INSURECO
Secondary Insurance	NIGHT FLYER

Questions

• Questions?

Call **(650) 498-7200** or **(800) 333-7491** to reach Customer Service during our regular business hours (Monday - Friday, 8:00 am to 5:00 pm) or our new Automated Voice Telephone System 24 hours a day, 7 days a week.

• Billing Office Location:

2690 Hanover Street in Palo Alto, CA.
Hours are Monday-Friday from 9:00 am to 4:00 pm.

• Mail Payments To:

Stanford Hospital & Clinics
File 74431 PO Box 60000
San Francisco, CA 94160

• Make Checks or Money Orders Payable to:

Stanford Hospitals & Clinics

Statement Date: 06/18/2004

999999999999 \$ 2,570.26

REMIT THIS PAYMENT STUB TO:

STANFORD HOSPITAL & CLINICS
FILE 74431 PO BOX 60000
SAN FRANCISCO, CA 94160



Patient Name	Medical Record	Date Due
SAMPLE A. SAMPLE	99999999	Upon Receipt
Amount Due	Amount I Am Paying	
\$ 2,570.26	\$	

Check here if your address or insurance information has changed. Please indicate changes on the back of this page.

To pay by credit card: For your convenience, you may pay by Visa, MasterCard, Discover, or American Express. Please indicate your credit card preference, provide the account information, and sign below.



Account No. _____

Expiration Date _____

Signature X _____

I authorize Stanford Hospital & Clinics to charge my credit card for the amount indicated.

SUMCD1S1-01

Hospital Account Statement – page 2

Statement Date

06/18/2004

Account Number

999999999999

Page 2 of 2

Patient Services Provided - Itemized Charges

Summarized Detail of Stanford Hospital Account Number 999999999999

A summarized detail of services and charges for each outstanding account due is provided below. A complete itemized statement for each account is available upon request. Please keep this page for further reference.

Account Number: 999999999999 Service Date(s): 04/17/1997 Type of Service: Outpatient

A

D

Payment is due upon receipt. Please enter the amount you are paying on the remittance stub, detach, and send with your check, money order, or credit card information in the enclosed reply envelope.

Services and Charges

LABORATORY..... \$ 2,570.26

Total Charges..... \$ 2,570.26

Payments and Adjustments as of 06/18/2004

Patient Payments..... \$ 0.00

Insurance Payments..... \$ 0.00

Insurance Adjustments..... \$ 0.00

Other Adjustments*..... \$ 0.00

Amount You Owe for this Account.....\$ 2,570.26

E

B

You will receive a statement for each hospital account if and when the balance becomes your responsibility.

*See Reverse of Page One for Additional Information

Hospital Monthly Statement – page 1

Key to important information on your statement:

- A** - Account Number
- B** - Amount Due from You
- C** - Date Payment is Due
- D** - Date(s) of Service
- E** - Payment and Credit Activity
- F** - Insurance Information



Lucile Salter Packard
Children's Hospital

STANFORD UNIVERSITY MEDICAL CENTER

You will receive separate statements from Lucile Packard Children's Hospital and Stanford Hospital & Clinics.

SAMPLE A. SAMPLE
123 MAIN ST.
ANYTOWN, US 123451234

This is the Hospital Monthly Statement

Important Message

Thank you for selecting Stanford Hospital & Clinics.

This bill is a summarized statement of your hospital account(s) at Stanford Hospital. A complete itemized statement for each account is available upon request.

Please note your physicians will bill separately for their professional services.

Page 1 of 2

Accounts Now Due as of Statement Date *

Statement Date	07/13/2004
Account Number	Amount Due
999999999999	\$ 126.03
C Balance Due 07/27/2004	\$ 126.03

Questions

• Questions?

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• Billing Office Location:

2690 Hanover Street in Palo Alto, CA.
Hours are Monday-Friday from 9:00 am to 4:00 pm.

• Mail Payments To:

Stanford Hospital & Clinics
File 74431 PO Box 60000
San Francisco, CA 94160

• Make Checks or Money Orders Payable to:

Stanford Hospitals & Clinics

Insurance Information

Please confirm that the information is correct for:

Patient Name	SAMPLE A. SAMPLE
Medical Record No.	12345678
Guarantor Name	SAMPLE A. SAMPLE

Insurance information and payment activity on individual accounts are included in the attached detail.

Statement Date: 07/13/2004

999999999999	\$ 126.03
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REMIT THIS PAYMENT STUB TO:

STANFORD HOSPITAL & CLINICS
FILE 74431 PO BOX 60000
SAN FRANCISCO, CA 94160



Patient Name	Medical Record	Date Due
SAMPLE A. SAMPLE	12345678	07/27/2004
Amount Due	Amount I Am Paying	
\$ 126.03	\$	

Check here if your address or insurance information has changed. Please indicate changes on the back of this page.

To pay by credit card: For your convenience, you may pay by Visa, MasterCard, Discover, or American Express. Please indicate your credit card preference, provide the account information, and sign below.



Account No. _____

Expiration Date _____

Signature X _____

I authorize Stanford Hospital and Clinics to charge my credit card for the amount indicated.

SUMC01

Statement Date
07/13/2004
Medical Record Number
12345678
Page 2 of 2

Patient Services Provided - Itemized Charges

Monthly Detail of Stanford Hospital Account(s) Due For **SAMPLE A. SAMPLE**

A summarized detail of services and charges for each outstanding account due is provided below. A complete itemized statement for each account is available upon request. Please keep this page for further reference.

Account Number: 999999999999 **Service Date(s): 08/19/2002 - 08/19/2003** **Type of Service: INPATIENT**

Primary Insurance: INSURECO
Secondary Insurance:

Account Activity Since Last Statement

Previous Balance.....	\$ 126.03
New Charges/Charge Adjustments*.....	\$ 0.00
Patient Payments.....	\$ 0.00
Insurance Payments.....	\$ 0.00
Insurance Adjustments.....	\$ 0.00
Other Adjustments*.....	\$ 0.00

Amount You Owe for this Account..... \$ 126.03

Payment is due on or before 07/27/2004

* See Reverse of Page One for Additional Information

The hospital will send you a monthly summarized statement for all of the hospital accounts that have a current balance that is your responsibility.

Physician Statement – side 1



Professional Services Operations
Physician Billing
File 74432 PO Box 60000
San Francisco, CA 94160-0001
www.stanfordhospital.com

TAX ID: 77-0465765

1V00001 9999999

9999999
SAMPLE A SAMPLE
123 S MAIN ST
ANYTOWN USA 12345-1234



Account Summary

A Account Number	9999999	E
Patient Payments (Last 30 Days)	\$ 0.00	
Total Account Balance	\$ 560.46	B
Charges Pending With Insurance	\$ 218.00	
Amount Due	\$ 342.46	

Insurance Information

Please confirm that information is correct.

PRIMARY
Insurance MEDICARE ASSIGNED 301
Address _____
City/State/ZIP _____
Group/Plan _____

Our records show that you have one insurance plan.
If you are covered by any other insurance plans, please contact a patient account representative.

A New Billing Statement for You!

As a result of suggestions made to us by patients just like you, we have re-designed our statement to provide you with complete, easy-to-read information about your bill. Thank you for your suggestions and your continued support. We are committed to continuing our efforts to improve the quality of service that we provide for you!

Statement Date
05/28/2004

Your Physician Statement

Page 1 of 2

About Your Statement

Thank you for choosing Stanford University Medical Center for your health care needs. This is a statement of your account for services provided by our physicians. Detailed information on each service rendered can be found on the following pages. The balances due for each service are added together to arrive at the total amount due from you.

Please send payment in full for \$ 342.46 by 06/08/2004.

If you have any questions, please call us at 1-800-549-3720 or 1-650-498-5850. Our patient account representatives are available from 9:00 am to 12:30 pm & 1:30 pm to 4:00 pm. Monday-Friday, or use our Automated Voice Telephone System which is available 24-hours a day.

NOTE: This is a statement for physician services ONLY. You may receive a separate bill for hospital services and/or clinic facility fees.

Key to important information on your statement:

- A** - Account Number
- B** - Amount Due from You
- C** - Date Payment is Due
- D** - Date(s) of Service
- E** - Payment and Credit Activity
- F** - Insurance Information

Please See Reverse Side For Account Detail →



Statement Date: 05/28/2004

Patient Name	Account Number	Date Due
Sample A Sample	9999999	06/08/2004
Amount Due	Amount Enclosed	
\$ 342.46	\$	

MAKE CHECKS PAYABLE TO:

STANFORD MEDICAL CENTER
FILE 74432 PO BOX 60000
SAN FRANCISCO, CA 94160-0001



Check here if your address or insurance information has changed. Please indicate changes on the back of this page.

To pay by credit card: For your convenience, you may pay by Visa, MasterCard, Discover, or American Express. Please indicate your credit card preference, provide the account information, and sign below.



Account No. _____

Expiration Date _____

Signature X _____

SUMC04

Physician Statement – side 2

Statement Date

05/28/2004

Account Number

9999999

Patient Statement for Sample A Sample

A summary of services, charges, claims and payments is provided below.
Please keep this page for further reference.

Page 2 of 2

Summary of Services and Amounts Due

Invoice Number: 99999999

Provider: Jane Perkins, MD, Nephrology

Service Date: 01/25/2003 **D**

Location: Inpatient

Your insurance plan has responded with payment, adjustment and/or denial as indicated below. Payment for this balance (and other balances due) can be made by paying the full amount due as shown on the payment stub of this statement.

Services and Charges

01/25/2003	99232	SUBSEQUENT HOSP. CARE	180.00
01/26/2003	99232	SUBSEQUENT HOSP. CARE	180.00
01/27/2003	90935	HEMODIALYSIS, SINGLE EVAL.	537.00
01/28/2003	90935	HEMODIALYSIS, SINGLE EVAL.	537.00
01/29/2003	90935	HEMODIALYSIS, SINGLE EVAL.	537.00
		Total Charges	\$ 1971.00

Claims and Payment Activity **E**

04/11/2003	Insurance Claim Filed	
06/13/2003	Insurance Payment	
	Payment	0.00
	Adjustment	0.00
08/28/2003	Insurance Payment	
	Payment	-383.49
	Adjustment	-1227.51
08/28/2003	Insurance Payment	
	Payment	0.00
	Adjustment	0.00
01/14/2004	Medicare Claim Filed	
01/29/2004	Medicare Payment	
	Payment	-17.54
	Note: Applied to Deductible	

Amount Now Due For This Service \$ 342.46

ICD9: 585

Referring Physician: Ronald Smith, MD

You will receive a
separate
statement of
account
for services
provided by our
physicians.

Change of Patient/Guarantor Information

New Address	City	State	Zip Code	New Phone #
Is this your Primary or Secondary insurance ? (Circle one)				
PRIMARY		SECONDARY		
Policy Holder (as it appears on the insurance card)	Policy/Identification #	Group #	Date of Birth	Coverage Effective Date
Group Name or Policy Holder's Employer/Union		Insurance Company Name		
Insurance Company Claim Address		Insurance Company Phone Number		