Statement of Services

Statement Date:	11/07/16
Patient Name:	Fortytwo Statement Test
Guarantor Account Number:	304551464
Medical Record Number:	2707636

Account Summary

Previous Statement Amount:	$314.00
New Services:	$329.00
Insurance Payments:	$0.00
Insurance Adjustments:	$0.00
Patient Payments:	$-35.00
Other Adjustments:	$0.00
Account Balance:	$608.00
Amount Due by November 25, 2016	**$608.00**

MyChart or Pay Online:
View clinical information, review your statement, make payments, and more! Visit us at: *http://mychartuva.com*
Activation code: 7C8DT-VH54C-2ZGSQ

Pay by Phone: (434) 980-6110
Automated account inquiry and bill payment system is available 24 hours a day 7 days a week.

Pay by Mail
Complete the form below and return in the enclosed envelope.

Billing questions? (434) 980-6110
Our office hours are 8 am to 5 pm Monday through Friday.

Financial Assistance: (866) 320-9659
If you lack financial resources, you may be eligible for financial assistance.

Important Information

Thank you for selecting University of Virginia for your health care needs. According to our records, you are responsible for the amount indicated. If you would like to speak with our UVA Health System Patient Billing Office please call (434) 980-6110.

Please detach this coupon and return with your payment in the enclosed envelope. Make checks payable to UVA Health System.

Po Box 800750 Charlottesville, VA 22923

IF PAYING BY CREDIT CARD PLEASE FILL OUT BELOW
☐ VISA ☐ MasterCard ☐ DISCOVER ☐ AMERICAN EXPRESS
CARD NUMBER:
EXP. DATE:
SIGNATURE:

☐ Check here if address or insurance information has changed and fill in the information on the back.

GUARANTOR ACCT NUMBER	AMOUNT DUE	DUE DATE	PAYMENT AMOUNT
304551464	**$608.00**	**11/25/16**	$

FORTYTWO STATEMENT TEST
1942 STATEMENT TEST LANE
ROSELAND, VA 22976

UNIVERSITY OF VIRGINIA HEALTH SYSTEM
PO BOX 800750
CHARLOTTESVILLE, VA 22923

030455146411252016000000608002

This billing statement represents hospital and physician charges for UVA Health System.

Financial Assistance:
If you lack financial resources, you may be eligible for financial assistance.To inquire about our program, you can visit our website at **uvahealth.com/finassist** or call **(434) 924-8718 or (866) 320-9659**. A completed application is required, including documentation of all assets. Below are the current eligibility criteria for a household of up to five members.

Number in Household Including Self	Gross Annual Household Income		Assets (such as bank or retirement accounts)
1	Less than $23,341	And	Less than $2,000.00
2	Less than $31,461	And	Less than $3,000.00
3	Less than $39,581	And	Less than $3,100.00
4	Less than $47,701	And	Less than $3,200.00
5	Less than $55,821	And	Less than $3,300.00

Affordable Care Act:
If you are without health insurance coverage, you are likely eligible to obtain coverage through the Health Insurance Marketplace. The statewide number is **(888) 392-5132** (toll free) and the web site is: **www.enroll-virginia.com** If your income is below the amount in the chart above financial help may be available to lower the cost of insurance.

Other Bills You May Receive:
You may receive bills from your own doctor, doctors who assisted in your care, or from other facilities. These doctors and facilities bill for their services separately, and may include:

UVA Imaging	(866) 591-5559 (toll free)
Community Medicine	(434) 243-4503
Health South	(800) 388-2451 ext. 1087 (toll free)
Continuum Home Health	(434) 984-2273 or (800) 336-4040 (toll free)

If you have a dispute over your bill or make a partial payment intended to be payment in full, direct all correspondence to: UVA Health System 4105 Lewis and Clark Drive Charlottesville, VA 22911

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

ABOUT YOU:	**ABOUT YOUR INSURANCE:** Will this ☐ replace or ☐ supplement existing coverage?
Your Name:	Policy Holder:
Address:	Date of Birth:
	Insurance
City:	Name:
State: Zip:	Address:
Home Telephone:	City/State/Zip:
Work Telephone:	Phone Number:
Employer's Name:	**Policy Information**
Employer's Telephone Number:	Effective Date:
Employer's Address:	Policy Number:
City: State: Zip:	Group Number:
	Employer Name:

Statement Date: 11/07/16
Patient Name: Fortytwo Statement Test
Responsible Party: Fortytwo Statement Test
Guarantor Account Number: 304551464

Summary of Charges

New Services:

Date	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Patient Balance
Physician Services for **Fortytwo Statement Test** by Harry R Holt, MD				Account #14000004673	
10/25/16	OFFICE OUTPATIENT VISIT 40 MINUTES	$329.00			
	Your Amount Due				**$329.00**

Previously Billed:

Date	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Patient Balance
Physician Services for **Fortytwo Statement Test** by Joan McIlhenny, MD				Account #14000004137	
09/24/16	**Balance Forward**	**$329.00**		**-$15.00**	**$314.00**
	PATIENT PAYMENT - 10/25/16			-$35.00	
	Your Amount Due				**$279.00**

Total Amount Due by November 25, 2016: **$608.00.**