

Reading Your Statement

- 1 **Patient's name and the name of the Guarantor** (the person legally responsible for paying the bill).
- 2 **Guarantor account number**—This is your financial account with UT Southwestern. Please refer to this number if you contact us with questions.
- 3 **Charges**—total charged by UT Southwestern for health care services rendered to the patient
- 4 **Adjustments and payments**—credits to your account for any payments your insurance company or you have already made (such as copays or coinsurance); any contractual adjustments given by your insurance company; and any other discounts made to your account.
- 5 **Patient Outstanding Balance**—total amount that you (the guarantor) owe UT Southwestern
- 6 **Payment Due Now**—portion of your total balance that you (the guarantor) owe this month.
- 7 **Payment Options**—you can pay your bill via MyChart or over the phone with a credit or debit card, or you can pay by mail with a credit or debit card or personal check.

UTSouthwestern
Medical Center

Statement Date
December 08, 2015

Billing Statement for: **John Sample Doe**
Guarantor: **John Sample Doe**
Guarantor Account: **3225784**

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This bill is for services by UT Southwestern providers and UT Southwestern Clinics and Hospitals.

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Your Account Summary

Charges	1,234.00	Balance not on Payment Plan	366.00
Adjustments	-12.55	Payment Plan Amount Due	18.98
Payments	-722.59		
Pending with Insurance	-0.00		

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Patient Outstanding Balance

Balance on Payment Plan	498.86	Payment Due Now	\$384.98
Balance not on Payment Plan	132.86		
	366.00		

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Payment Options

Pay online at www.mychart.utsouthwestern.edu
(Available 24/7)

Pay-by-phone 469-291-2000

Mail check or credit card information with section below

Questions?
469-291-2000

Detach section below and return with payment. Please make checks payable to UT Southwestern and write your guarantor account number on the check.

Statement Date: 12/08/15

UTSouthwestern
Medical Center

UT Southwestern
Return Mail Processing
P O BOX 2156
Morrisville, NC 27560

☐ Please check box if your address is incorrect or your insurance information has changed and indicate the change(s) on the reverse side.

For credit card payments, complete section below.

Payment Method
☐ Credit/Debit ☐ Check

Credit Card Information
☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

CARDHOLDER NAME
CARD #
EXP DATE
CODE
SIGNATURE

What You Owe:
\$384.98

Guarantor Account: 3225784

Amount authorized or enclosed

Payment due upon receipt

John Sample Doe
123 Sample St
DALLAS TX 75201

UT Southwestern
P O BOX 848009
Dallas, TX 75284-8009

Reading Your Statement

- 8 Payment Plan Information**—if you are paying your balance on an installment plan, the summary of that plan is listed here.
- 9 Service Details**—these sections list the services provided by UT Southwestern and detail the charges, adjustments and discounts, and payments for each.
- A** Place of the service and date range of the billing transactions for that service
 - B** Health care service that was provided by UT Southwestern
 - C** Adjustments, discounts or payments by the patient's insurance company
 - D** Payments made by you (guarantor); this might include your copay, coinsurance, or deductible payment(s)
 - E** Your Responsibility—the amount you (guarantor) owe for that specific service. This is NOT your total balance due.
- 10 Statement Totals**—this is the sum total of each column, including total charges (shown as **3** on the first page), total payments and adjustments (shown as **4** on the first page), and total patient balance (shown as **5** on the first page).

UTSouthwestern
Medical Center

Billing Statement for: John Sample Doe
Guarantor: John Sample Doe
Guarantor Account: 3225784

Thank you for entrusting UT Southwestern Medical Center with your recent healthcare needs.
 If applicable, your insurance has been billed and any available benefits have been applied. The remaining balance is due now and can be paid online, by telephone, or by mail.

Billing Questions:
 Weekdays 8 am - 5 pm
 Phone: 469-291-2000
 Fax: 469-291-2394

To request an itemized bill:
 469-291-2000

Statement Date: 12/08/15
Primary Insurance: BLUE CROSS BLUE SHIELD - BCBS PPO

Payment Plan Information
 Remaining Balance: 132.86
 Number of Payments Left: 7
 Monthly Amount: 18.98
 Current Amount Due: 18.98

Hospital Services on Payment Plan for John Sample Doe

Date	Code	Description	Charges	Pmts/Adjs	Insurance Balance	Patient Balance
Services at Clements University Hospital September 05, 2015 to October 01, 2015			Acct: 400153782			
		Balance Forward				\$0.00
	0300	LABORATORY - GENERAL	854.00			
Oct 19, 2015		BCBS Payments		722.59		
		Coinsurance: 127.36				
Oct 14, 2015		Adjustments		4.05		
		Totals	854.00	726.64		\$127.36
		Your Responsibility				\$127.36

Physician Services on Payment Plan for John Sample Doe

Date	Code	Description	Charges	Pmts/Adjs	Insurance Balance	Patient Balance
Physician Services September 15, 2015 to September 15, 2015			Acct: 400153791			
		Balance Forward				\$0.00
		CUH PATHOLOGY with Ravindra Sarode, MD				
Sep 15, 2015	85025	COMPLETE CBC W/AUTO DIFF WBC	14.00			
		Totals	14.00	8.50		\$5.50
		Your Responsibility				\$5.50

Physician Services not on Payment Plan for John Sample Doe

Date	Code	Description	Charges	Pmts/Adjs	Insurance Balance	Patient Balance
Physician Services December 07, 2015 to December 07, 2015			Acct: 7895983			
		Multi-Specialty with Steven L. Leach, MD				
Dec 07, 2015	99215	OFFICE/OUTPATIENT VISIT EST	366.00			
		Totals	366.00			\$366.00
		Your Responsibility				\$366.00
		Statement Totals	1,234.00	-735.14	0.00	498.86