Date:

P.O. Box 473 Amherst, NH 0 03031

[NAME]

[ADDRESS]

[CITY], [STATE] [ZIP]

Acct. Number:
Service Date: [Admit DATE] - [Discharge DATE]
Patient Name:
Balance Due:

$☐☐☐☐☐.☐☐
Amount Enclosed **(If paying by Credit Card, please complete info on back)**

Remit To:
Benedictine Hospital
P.O. Box 1958
Kingston, NY 12402

▲PLEASE ENCLOSE THIS PORTION WITH YOUR PAYMENT▲
▲PLEASE SEE BACK SIDE TO FURNISH ADDITIONAL INSURANCE INFORMATION OR TO PAY BY CREDIT CARD▲

Thank you for choosing Benedictine Hospital. Your satisfaction is our primary concern. We have billed your insurance company; however there is a remaining balance as shown below. The balance is your responsibility; please remit payment in full today. Please contact us immediately to establish a payment arrangement or if you have secondary medical insurance that you did not furnish at the time of your visit.

Bill for Medical Services for your Visit on [Admit DATE] through [Discharge DATE]

Charge Information

[CDESC1] Description of your 1st charge
[CBAL1] Fee for 1st charge summary
[CDESC2] Description of your 2nd charge
[CBAL2] Fee for 2nd charge summary

Insurance Information

[INSNAM1] Name of your insurance carrier
[INSNAM2] Name of your 2nd insurance carrier

Payments and Adjustments

[PDESC1] Name of primary insurance carrier or payer
[PBAL1] Actual payment from primary insurance carrier or payer
[ADESC1] Description of adjustment from primary insurance carrier or payer
[ABAL1] Financial adjustment from primary insurance carrier or payer
[PDESC2] Name of secondary insurance carrier or payer

A separate charge may be generated for professional fees; for the physician who treated you or for the interpretation of any tests performed. Not all physicians that provide services may participate with your insurance carrier, thus an additional bill may be submitted to collect for fees associated with the services rendered.

Balance Due: $

Benedictine Hospital's Financial Assistance

If you qualify, it may cover all or part of the cost of your care. For more information, please contact a Financial Counselor at the number below or complete and return the "Application for Hospital Financial Assistance" on the back of this statement.
Aplicación de Caridad está disponible en español. Por favor llámenos.

Billing Questions

Hours: Weekdays 8:00am to 4:00 pm
Phone: 845-334-2743
Address: 105 Mary's Avenue
Kingston, NY 12401
http://www.benedictine.org

For your convenience you may charge the balance to your Visa, MasterCard, Discover or American Express by calling Patient Accounting at 845-334-2743, filling out the back side of the payment slip above or you can also pay online with your credit card by visiting our website, www.hahv.org

Account Information

Statement Date:
Acct. Number:
Service Date: [Admit DATE] - [Discharge DATE]
Patient Name:
Balance Due:

Important: If you believe this bill is for services not rendered to you, or you believe you have been a victim of medical identity theft, please contact our office at 845-334-2743.