

| | | | | | |
|--------------------------|--|---------------------------------|---------------------|-------------------|-------------|
| PATIENT | | OUTGOING RETURN ADDRESS HERE | | | IRS NO. |
| ACCOUNT NUMBER | STATEMENT DATE | BILLING OFFICE PHONE | | | |
| DATE | EXAM CODE | DESCRIPTION | DX CODE | AMOUNT | |
| REFERRING PHYSICIAN | | DATE ADMITTED | DATE DISCHARGED | PATIENT PHONE NO. | BALANCE DUE |
| PLACE OF SERVICE NOTE | PLACE OF SERVICE | | | DATE OF BIRTH | INJURY DATE |
| | 1. INPATIENT HOSPITAL 2. OUTPATIENT HOSPITAL 3. DOCTOR'S OFFICE 4. EMERGENCY ROOM | | | EMPLOYER | |
| | | | PRIMARY INSURANCE | | |
| | | | SECONDARY INSURANCE | | |
| | | | ATTENDING PHYSICIAN | | |

RETURN THIS PORTION WITH PAYMENT
STATEMENT

| | |
|----------------|----------------|
| ACCOUNT NUMBER | STATEMENT DATE |
|----------------|----------------|

AMOUNT REMITTED \$

MAKE CHECK PAYABLE TO:

REPLY ENVELOPE ADDRESS
HERE

BILL TO:

OUTGOING ADDRESS
HERE

DM-027 • 7 Parts • 12" x 5 1/2" • Third Generation National Medical Format • Two Inserts for Patient and Insurance Filing • Two-Way, Zip-Style Construction • Return Envelope • Account Number Transfer to Return Envelope • Burgundy/Blue Inks • Reference HC2-701

| | | | | | |
|---------------------|-------------------------|----------------|---------------------|---------------------|-------------|
| | | | | PATIENT'S NAME | |
| | | IRS NUMBER | ACCOUNT NUMBER | | |
| DATE | DESCRIPTION OF SERVICES | DIAGNOSIS | AMOUNT | | |
| LOCATION OF SERVICE | | | | | BALANCE DUE |
| INJURY DATE | ADMISSION DATE | DISCHARGE DATE | REFERRING PHYSICIAN | | |
| | | | | ATTENDING PHYSICIAN | |
| | | | | STATEMENT DATE | |

STATEMENT

Return this section with your payment

| | |
|------------------------|-------------------------|
| ACCOUNT NUMBER | STATEMENT DATE |
| PATIENT'S PHONE NUMBER | PATIENT'S DATE OF BIRTH |
| EMPLOYER | PRIMARY INSURANCE |
| ADMISSION DATE | SECONDARY INSURANCE |

AMOUNT REMITTED \$

MAKE CHECK PAYABLE TO:

BILL TO:

If services were rendered at the hospital, this bill is separate from your hospital bill, see reverse side for explanation.

DM-028 • 7 Parts • 12 3/8" x 5 1/2" • Fifth Generation National Medical Format • Two Inserts for Patient and Insurance Filing • Two-Way, Zip-Style Construction • Return Envelope • Account Number Transfer to Return Envelope • Tan/Teal Inks • Reference HC2-702

| | | | | | | | |
|-----------------|----------------|----------------|-------------------------------------|---------------------|---------------------------|----------------|--|
| | | | | | | ACCOUNT NAME | |
| | | | STATEMENT DATE | ACCOUNT NUMBER | | | |
| DATE OF SERVICE | DIAGNOSIS CODE | PROCEDURE CODE | PATIENT'S NAME | ATTENDING PHYSICIAN | AMOUNT DUE | | |
| | | | DESCRIPTION OF SERVICE AND PAYMENTS | | | | |
| CURRENT | 1-30 DAYS | 31-60 DAYS | 61-90 DAYS | OVER 90 DAYS | AMOUNT DUE FROM INSURANCE | AMOUNT DUE NOW | |
| | | | DESCRIPTION OF SERVICE AND PAYMENTS | | | | |

STATEMENT

RETURN THIS PORTION WITH PAYMENT

| | |
|---------------------------|-----------------------------|
| ACCOUNT NUMBER | STATEMENT DATE |
| AMOUNT DUE FROM INSURANCE | AMOUNT DUE NOW FROM ACCOUNT |
| TOTAL ACCOUNT BALANCE | AMOUNT REMITTED |

AMOUNT REMITTED \$

MAKE CHECK PAYABLE TO:

BILL TO:

SEE REVERSE SIDE FOR PLACE OF SERVICE

DM-037 • 7 Parts • 12 1/2" x 5 1/2" • National Medical Statement • Two Inserts for Patient and Insurance Filing • Two-Way, Zip-Style Construction • Return Envelope • Account Number Transfer to Return Envelope • Blue/Red Inks • Reference HC2-703