

# HOW TO READ YOUR STATEMENT

- 1 Credit Cards – We accept all major Credit Cards and Debit Cards including MasterCard, Visa, Discover, and American Express (See reverse side of statement)
- 2 Account Number – Please reference this number when contacting our office
- 3 Amount – Amount due from you for this statement
- 4 Name and Address of Guarantor/Responsible Party
- 5 Remittance Portion – Tear on the perforation and return this portion of your statement with your payment. Keep the lower portion for your records.
- 6 Address Change – Check this box if information has changed. (See the reverse side of statement)
- 7 Date – Date on which the service was provided
- 8 Provider – Provider who performed the services (If the line item doesn't have a provider name, then the item is for hospital services.)
- 9 Description – Description of services provided
- 10 Patient Name – Name of patient who received these services
- 11 Charges and Payments – Charges, payments, and/or adjustments for this billing period
- 12 Amount – Balance due for each visit
- 13 RMK – Remark #. (see message below in the body of the statement with this remark #)
- 14 Enc# - Reference number for this visit
- 15 Encounter Total – Total due from you for this visit
- 16 Remark Message – Messages related to the RMK #.
- 17 Information to register for online account

**TRINITY HEALTH**  
 P.O. Box 5010 Minot, ND 58702-5010  
 ADDRESS SERVICE REQUESTED

If paying by one of these credit cards, please enter the information on the reverse side.

1

STATEMENT DATE	ACCOUNT NUMBER	AMOUNT
05/05/2011	2 9999999	3 \$827.68

Indicate Amount Paid \$

4 SUZY SUNSHINE  
 1234 ANY STREET  
 MINOT ND 58701

5 MAKE CHECK PAYABLE TO:  
 Trinity Hospitals  
 P.O. Box 5010  
 Minot, ND 58702-5010

6  Please detach and return top portion with payment. Check box if address is incorrect or has changed and indicate change(s) on reverse side.

Co-pays are due at the time you receive services. If your insurance requires a co-pay, please be prepared to pay your co-pay when you arrive for your appointment.

## STATEMENT

7 GUARANTOR NUMBER	8 STATEMENT DATE	9 DUE DATE	10 RESPONSIBLE PARTY	11 PAY THIS AMOUNT
9999999	05/05/2011	Upon Receipt	SUZY SUNSHINE	\$827.68

7 DATE	8 PROVIDER	9 DESCRIPTION	10 PATIENT NAME	11 CHARGES AND PAYMENTS	12 AMOUNT	13 RMK
	Enc#4125592					S1
02/03/2011	DOCTOR MD	Laboratory	JENNIFER		20.10	
02/03/2011	DOCTOR MD	Lab/Chemistry	JENNIFER		773.20	
	*** Encounter Total ***				793.30	
	Enc#4207881					I1
03/17/2011	DOCTOR MD	Lab/Bact-Micro	JENNIFER		74.50	
03/17/2011	DOCTOR MD	Lab/Urology	JENNIFER		33.10	
03/23/2011		BILLED BLUE CROSS BLUE SHIELD	JENNIFER		0.00	
04/01/2011		BCBS PAYMENT	JENNIFER		0.00	
04/01/2011		BCBS ADJUSTMENT	JENNIFER		-73.22	
	*** Encounter Total ***				34.38	

14 S1 Thank you for choosing Trinity Health for your healthcare needs. Your balance due is listed above and we have enclosed an envelope for your convenience.

15 I1 Thank you for choosing Trinity Health for your healthcare needs. Our records indicate insurance has processed this date of service and the remaining balance is your responsibility.

17 **Trinity Health is offering the ability for you to make your payments on line. This new service is secure, convenient and allows you to view your account statements or invoices online. You will receive your document by email to an address that you set up online. Enroll at <https://trinity.webview.com/> with the enrollment number located in the bottom left hand corner of your statement or invoice, it is free and secure and you can change your mind anytime.**

All Charges Due Upon Receipt of this statement. If you cannot pay the balance in full or have questions about your statement, please contact our Business Services Department. (See contact information on the back of this statement.)

Online Enrollment Number: 0