



Your Yampa Valley Medical Center Statement



Thank you for choosing us for your medical needs. We have billed your insurance carrier(s).

The balance on this statement is your responsibility. Please pay your balance in full or contact customer service at **1.855.432.4305**.

Online Quick Pay
<https://billpay.uhealth.org>

► SUMMARY OF CHARGES

Room and Board	\$1,200.00
Laboratory	\$645.00
Radiology	\$806.00
Anesthesia	\$482.00

► ACCOUNT SUMMARY

Patient Name	John B. Patient
Guarantor Name	John B. Patient
Account Number	20001121234
Service Date(s)	12/10/17 – 12/10/17
Total Charges	\$ 3,133.00
Insurance Payments	\$ 872.25
Insurance Adjustments	\$ 1,596.75
Patient Payments	\$ 100.00
Patient Adjustments	\$ 0.00
Statement Date	03/12/18

<i>Current Due</i> Statement 1	<i>30 – 60 Days</i> Statement 2	<i>60 – 90 Days</i> Statement 3	<i>90 – 120 Days</i> Statement 4
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\$564.00

Summary of Charges \$3,133.00

Current Due \$564.00

► CONTACT US

Pay your bill easily and securely online, by mail or call our Customer Service representatives at **1.855.432.4305**.
Phone Hours: 8:00 am – 5:00 pm, M-F (MST)

Online Quick Pay
<https://billpay.uhealth.org>

See back of statement for more information



PO BOX 733885
DALLAS TX 75373-3885
ADDRESS SERVICE REQUESTED



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

IF PAYING BY CREDIT CARD, PLEASE FILL OUT BELOW.		
		AMOUNT PAYING \$
CARD NUMBER		CODE*
SIGNATURE		EXP DATE
STATEMENT DATE 3/12/18	PAY THIS AMOUNT \$564.00	ACCOUNT # 20001121234

*The code is the 3 digit code found on the back or the 4 digit code on the front if using an Amex card.





MAKE CHECKS PAYABLE AND REMIT TO:

UCBA11-21234567
JOHN SMITH
123 MAIN STREET
FT COLLINS CO 81234

BUSINESS SERVICES – PATIENT ACCOUNTS
PO BOX 733885
DALLAS, TX 75373-3885





 <p>PAY YOUR HOSPITAL BILL ONLINE: Online bill pay is now available. Access our Quick Pay site at: https://billpay.uchealth.org</p>	 <p>PAY YOUR HOSPITAL BILL BY PHONE: Our Customer Service Representatives are available Monday - Friday 8:00 am to 5:00 pm (MST). Call us at 1.855.432.4305.</p>
 <p>PAY YOUR HOSPITAL BILL BY MAIL: Please write your account number and mail it with the bottom portion of your statement. We also accept personal checks or money orders.</p>	 <p>OTHER PAYMENT OPTIONS: If you are unable to pay your medical bill or would like to set up a payment plan, we may be able to assist you. Call us at 1.855.432.4305.</p>

❖ **WHAT YOU NEED TO KNOW:**

Per Colorado State Senate bill 12-134, uninsured patients who meet eligibility requirements are qualified to be screened for financial assistance. CICIP recipients do not qualify for this program. If you are uninsured and need assistance with your medical bill, please call our customer service department at 1.855.432.4305.

Por el Senado del estado de Colorado 12-134 pacientes no asegurados que cumplan con los requisitos de elegibilidad están calificados para ser evaluados para la asistencia financiera. Los destinatarios CICIP no califican para este programa. Si usted es un paciente sin seguro y necesita ayuda con su cuenta médica, por favor llame a nuestro departamento de servicio al cliente al 1.855.432.4305y oprima la opción 1 para la asistencia en español.

❖ **WHY DID I GET TWO BILLS?**

This is your hospital bill. It includes charges for use of its equipment, supplies, and technical personnel. Physicians (providers) bill separately for their charges. Please contact the number on that statement.

❖ **FINAL NOTICE* / COLLECTIONS:**

UCHealth sends four statements, including a final notice. Payment is due within 30 days of your statement date. Upon receipt of final notice and failure to pay your bills or contact our office will result in your account being considered for assignment to an outside collections agency.

❖ **NEED TO UPDATE YOUR ADDRESS OR INSURANCE INFO?**

Please fill out the form below with your updated information and mail it back to us. Allow 7-10 business days for the updates to reflect in our system.

TO UPDATE YOUR ADDRESS OR INSURANCE INFORMATION, COMPLETE AND RETURN THE FORM BELOW.

Patient Name		Phone #	
Address		City	State Zip Code
PRIMARY INSURANCE COVERAGE	Patient's Relationship to Insured <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	SECONDARY INSURANCE COVERAGE	Patient's Relationship to Insured <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER
Insurance Company	Phone # ()	Insurance Company	Phone # ()
Address		Address	
Policy Holder's Name	Birth Date / /	Policy Holder's Name	Birth Date / /
Policy & Group #	Policy Effective Date / /	Policy & Group #	Policy Effective Date / /
Employer's Name	Phone # ()	Employer's Name	Phone # ()
Address		Address	