IF PAYING BY MASTERCARD, DISCOVER OR VISA, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTER ☐ DISCOVER ☐ VISA

CARD NUMBER	EXP. DATE	* ID CODE
NAME ON CARD	SIGNATURE	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NUMBER
10/07/2014	$58.26	1 80001234

*LAST THREE DIGITS ON BACK OF CREDIT CARD

SHOW AMOUNT PAID HERE $

CLAY COUNTY MEDICAL CENTER
PO BOX 512
CLAY CENTER KS 67432-0512

785-632-2144
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QSC1009Z
4000000070 70/1

John A. Doe 2
123 1st St.
City, State Zip

CLAY COUNTY MEDICAL CENTER
PO BOX 512
CLAY CENTER KS 67432-0512

If you have questions regarding this statement or for information on Financial Assistance, please call our Patient Account Representative between 7 a.m. and 5:15 p.m., Monday through Friday at (785)632-2144. Financial assistance information is also available at www.ccmcks.org. Please ask about our prompt-pay discount.

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

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

STATEMENT

* IDENTIFICATION CODE: LAST THREE DIGITS ON BACK OF MC, DISCOVER, AND VISA

PATIENT NAME	VISIT NUMBER 4	SERVICE DATE 5	PAYOR 6	CUR BAL 7	ACCUMULATED BAL DUE 8
John A. Doe	00200100-0000	OHC 04/20/2014	Blue Cross		
510 Clinic				34.00	
152 Blue Cross Payment 3				-34.00	
New Balance of Account				0.00	0.00
End of Patient Statement					
John A. Doe	00201100-0000	IMG 08/10/2014	Blue Cross		
402 Ultrasound				370.30	
152 Blue Cross Payment		10/03/2014		-58.27	
361 Blue Cross Contractual Adjust-OP		10/03/2014		-253.77	
New Balance of Account				58.26	58.26
End of Patent Statement					
End of Guarantor Statement					

CURRENT 9	30-60 DAYS	60-90 DAYS	90-120 DAYS	OVER 120 DAYS	TOTAL ACCOUNT BALANCE
$58.26	$0.00	$0.00	$0.00	$0.00	$58.26

DUE FROM PATIENT $58.26 10

ACCOUNT NAME	ACCOUNT NUMBER	STATEMENT DATE
2 John A. Doe	1 80001234	10/07/2014

1. ACCOUNT NUMBER

This is the number that identifies the Guarantor for the patient(s). When calling in or mailing a payment, please supply this number to the representative. This will enable faster processing of your payment.

2. MAILING ADDRESS

This area displays the Guarantor name on the account as well as the mailing address. If this address is incorrect, please contact CCMC to update this information.

3. PATIENT NAME

This column will display each individual patient for whom the Guarantor is responsible for as well as all charges for services and payments, whether insurance or personal payments, which have been posted to the account as of the statement date.

4. VISIT NUMBER

If inquiring about a specific visit for a specific patient, please supply the representative with this number to help them better identify the exact concern or question you may have.

5. SERVICE DATE

The first date listed in line with the Patient Name is the service date. Any dates that may appear under the initial date and centered within this column will be related to the date payments and adjustments were made to the account from CCMC. This may not be the date as printed on an insurance Explanation of Benefits (EOB) or the date the payment was mailed.

6. PAYOR

This column will display the name of any insurance companies that have/will be billed. If no insurance is associated with the visit, then Private Pay/Self Pay will be displayed in this column to indicate that the full balance is the patient's responsibility.

7. CURRENT BALANCE

This column will display the amounts of charges, payments, and the balance due for each visit.

8. ACCUMULATED BALANCE DUE

This column will serve to show how the remaining charges are accumulated to equal the amount due from the patient.

9. AGE OF ACCOUNT SCALE

If you have any concern with the aging listed in this section, please contact us to review your account.

10. DUE FROM PATIENT

Please remember to call and ask about our Prompt Pay Discount if you plan to pay the balance in full within 28 days from the date of the first statement for a service date.