



New Haven Area Inquiries: 203-785-4216  
 Outside New Haven Area: 800-826-9922  
 Customer Service Hours: Mon-Fri, 8:00am-5:00pm  
 Website URL: www.yalemedicalgroup.org

PLEASE CHECK THIS BOX IF YOUR ADDRESS OR THE INSURANCE NAME AND POLICY # BELOW HAVE CHANGED. MAKE YOUR CHANGES ON THE REVERSE SIDE.  
 1. MEDICARE PART B 123456789A  
 2. NONE

**JOHN Q PUBLIC**  
 123 MAIN STREET  
 NEW HAVEN, CT 06513

PATIENT: JOHN Q PUBLIC	STATEMENT DATE: 01/08/04		
<b>MAKE CHECKS PAYABLE TO: YALE MEDICAL GROUP</b>			
<input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> AMERICAN EXPRESS <input type="checkbox"/> DISCOVER			
CARD NUMBER: _____			
EXP DATE: ___/___/___   SIGNATURE: _____			
<b>ACCT #</b>	<b>AMOUNT OWED</b>	<b>AMOUNT DUE NOW</b>	<b>AMOUNT ENCLOSED</b>
<b>X00999999</b>	<b>\$17.54</b>	<b>\$17.54</b>	<b>\$</b> <input type="text"/>

**MAIL PAYMENT TO:**  
 YALE MEDICAL GROUP  
 DEPT 5123  
 PO BOX 30000  
 HARTFORD, CT 06150-5123

Send correspondence to: Customer Support Services, PO Box 7309, New Haven, CT 06519-0309 or e-mail us at: patient.services@yale.edu

PLEASE DETACH TOP PORTION AND RETURN WITH YOUR PAYMENT

## STATEMENT OF PHYSICIAN SERVICES

(JANUARY 8, 2004)

**ACCOUNT NUMBER: X00999999**  
**PATIENT NAME: JOHN Q PUBLIC**

PAGE 1

THE FOLLOWING INVOICES DESCRIBE CHARGES FOR SERVICES PROVIDED BY THE YALE MEDICAL GROUP. THE LEFT COLUMN DESCRIBES THE SERVICES PROVIDED AND THE RIGHT COLUMN DESCRIBES PAYMENT ACTIVITY AND THE AMOUNT YOU OWE.  
 IF YOU ARE A MEDICAID PATIENT, PLEASE PROVIDE YOUR ID NUMBER ON THE REVERSE SIDE, AND MAIL IN THE PAYMENT COUPON WITH NO PAYMENT.  
 PLEASE NOTE THAT YOU MAY ALSO RECEIVE A SEPARATE STATEMENT FOR HOSPITAL SERVICES.

INVOICE NUMBER: 9999990 <b>CHARGES</b> PROVIDER: JANE TESTDOC MD 11/19/03 99214-DETAILED/MODERATE COMPLEXITY OFFICE/OUTPATIENT \$220.00 <b>TOTAL: \$220.00</b> DIAGNOSIS (ICD-9): V42.0	<b>PAYMENT ACTIVITY</b> 11/19/03 TOTAL CHARGES \$220.00 12/10/03 CLAIM SUBMITTED 12/30/03 MEDICARE PAYMENT PAYMENT..... -70.17 ADJUSTMENT..... -132.29 12/30/03 BALANCE BILLED TO PATIENT <b>AMOUNT DUE NOW..... \$17.54</b>
INVOICE NUMBER: 9999991 <b>CHARGES</b> PROVIDER: JOE TESTDOC MD 12/17/03 99213/24-EXPANDED PROBLEM/LOW COMPLEXITY OFFICE/OUTPA \$140.00 <b>TOTAL: \$140.00</b> DIAGNOSIS (ICD-9): V45.89, V42.0	<b>PAYMENT ACTIVITY</b> 12/17/03 TOTAL CHARGES \$140.00 12/30/03 CLAIM SUBMITTED WE HAVE FILED A CLAIM FOR \$140.00 WITH YOUR INSURANCE COMPANY AS A COURTESY TO YOU.

**THANK YOU FOR YOUR RECENT PAYMENT.**

ACCOUNT SUMMARY			
CURRENT	31-60 DAYS PAST DUE	OVER 60 DAYS DELINQUENT	TOTAL AMOUNT DUE
\$17.54	\$0.00	\$0.00	\$17.54

  

TOTAL ACCOUNT BALANCE .....	\$157.54
LESS: AMOUNT PENDING WITH INSURANCE ...	\$140.00
<b>TOTAL AMOUNT DUE NOW .....</b>	<b>\$17.54</b>

# Change of Name, Address or Insurance Coverage

<b>1. Patient Information</b>				<b>4. Other Coverage - Primary</b>			
Last Name _____		First Name _____		M _____		Insurance Co. Name _____	
Street Address _____				Plan Name _____			
City _____ State _____ Zip Code _____ Telephone Number _____				Street Address _____			
City _____ State _____ Zip Code _____ Telephone Number _____				City/State/Zip _____			
				Subscriber's Name _____			
				ID # _____		Effective Date _____	
				Group Name _____		Group Number _____	
<b>2. Medicare</b>				<b>5. Other Coverage - Secondary</b>			
ID # _____		<input type="checkbox"/> Primary Ins.		<input type="checkbox"/> Secondary Ins.		Insurance Co. Name _____	
Part A - Hospital Ins. <input type="checkbox"/>		Effective Date _____		Plan Name _____		Street Address _____	
Part B - Physician Ins. <input type="checkbox"/>		Effective Date _____		City/State/Zip _____		Subscriber's Name _____	
<b>3. Medicaid</b>				ID # _____ Effective Date _____			
Name on Card _____		<input type="checkbox"/> Primary Ins.		<input type="checkbox"/> Secondary Ins.		Group Name _____ Group Number _____	
		Effective Date _____					
a. State of CT ID # _____		Husky Program ID # _____					
b. City of _____		ID # _____					

\*\*\* If possible, please enclose a front & back copy of your Insurance ID Card with this change \*\*\*