



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. BANKERS LIFE AND CASUALTY 987654321

**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>MINIMUM DUE</b>	<b>AMOUNT ENCLOSED</b>
<b>X00999999</b>	<b>\$100.00</b>	<b>\$50.00</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**

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### PAYMENT PLAN SUMMARY

WE HAVE ESTABLISHED A PAYMENT PLAN OF \$25.00 PER MONTH ON THE BALANCE SHOWN BELOW. PLEASE PAY THIS AMOUNT EACH MONTH USING THE ATTACHED PAYMENT COUPON UNTIL THIS BALANCE HAS BEEN PAID IN FULL.

PAYMENT PLAN BALANCE AS OF 12/08/03 .....	\$100.00
PAYMENTS/ADJUSTMENTS RECEIVED SINCE 12/08/03 .....	0.00
CHARGES ADDED TO PAYMENT PLAN BALANCE .....	0.00
PAYMENT PLAN BALANCE AS OF THIS STATEMENT .....	\$100.00
PAYMENT PLAN AMOUNT .....	\$25.00
PAST DUE PAYMENT PLAN AMOUNT .....	+25.00
<b>MINIMUM PAYMENT PLAN AMOUNT DUE NOW .....</b>	<b>\$50.00</b>

OUR RECORDS INDICATE THAT YOU HAVE FAILED TO COMPLY WITH YOUR AGREED UPON PAYMENT PLAN. PLEASE REMIT AMOUNT NOW DUE TO OUR OFFICE WITHIN 10 DAYS TO AVOID FURTHER COLLECTION ACTIVITY.

### ACCOUNT SUMMARY

CURRENT	31-60 DAYS PAST DUE	OVER 60 DAYS DELINQUENT	TOTAL AMOUNT OWED
\$0.00	\$0.00	\$100.00	\$100.00

TOTAL ACCOUNT BALANCE .....	\$100.00
LESS: AMOUNT PENDING WITH INSURANCE ...	\$0.00
TOTAL AMOUNT OWED .....	\$100.00
<b>MINIMUM AMOUNT DUE NOW .....</b>	<b>\$50.00</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 \*\*\*