Front

Lifespan

164 SUMMIT AVENUE
PROVIDENCE, RI
02906

For Account Information, Please Call 401-444-6966

Patient Name
Service Date: 07/28
Service End:
Last Statement Date:
Account No: 111111111

Statement of Account *08/15/05*

Transaction Date	Description	Amount
	PREVIOUS BALANCE	672.00

Estimated Insurance Due: 562.80 Total Patient Credits: Account Balance: 672.00

OFFICE HOURS ARE MONDAY THRU FRIDAY, 9:00AM TO 4:30PM
PATIENT BALANCE DUE AND PAYABLE UPON RECEIPT. IF YOU HAVE QUESTIONS ON YOUR BILL-CALL (401)444-6966,M-F,9AM-4PM.

THE MIRIAM HOSPTIAL

Please detach and return with your payment

THE MIRIAM HOSPITAL
164 SUMMIT AVENUE
PROVIDENCE, RI
02906

ADDRESS SERVICE REQUESTED

For Hospital Use Only
ADM DT: 072805
DSH DT: *NONE*
FC: B
MR:
RC:
HR: TME
DP: 081105

Account Number: 1111111111
Please Pay This Amount: 109.20
Patient Name: Patient Name
Due By: 08/29/05
Card Number:
CVV2 No:*
Exp. Date:
Signature:
Amount Paid:

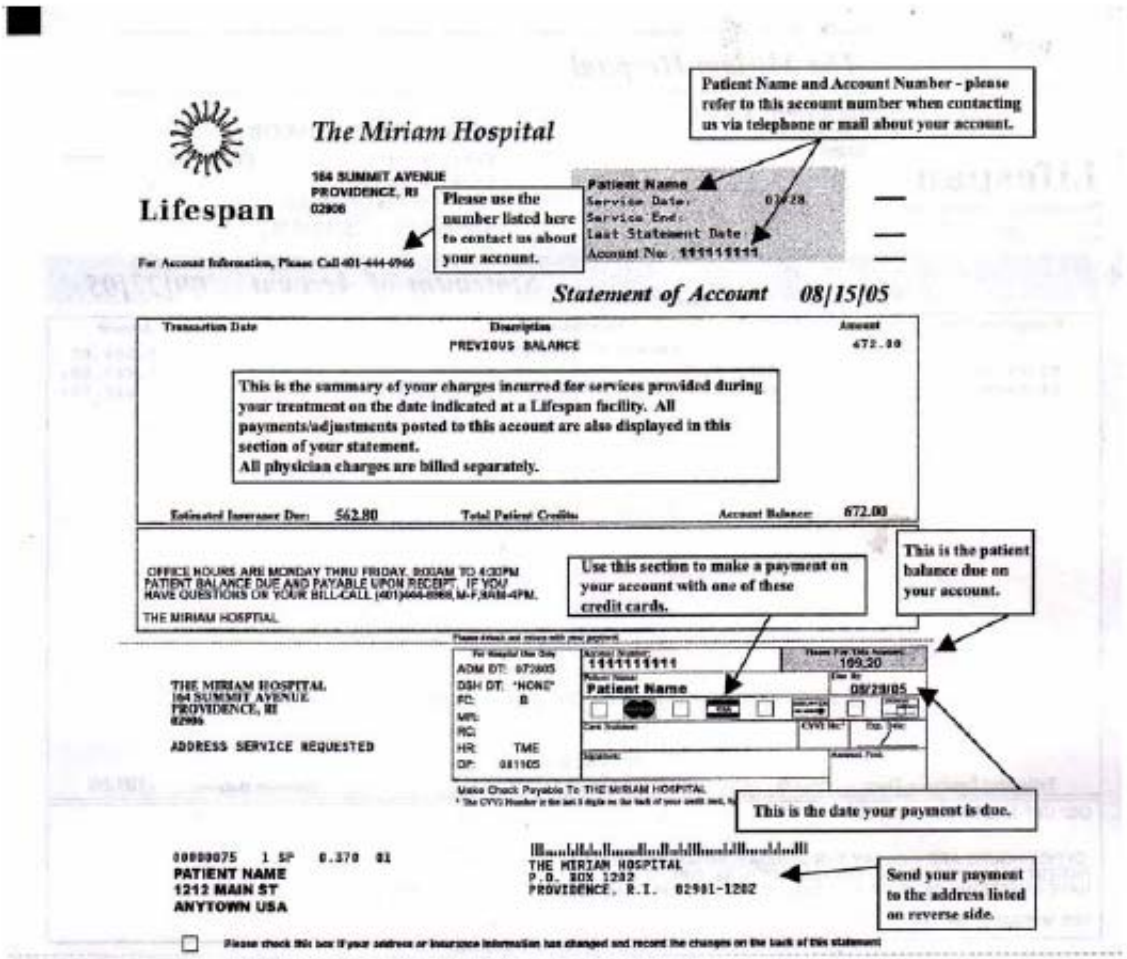
Make Check Payable To THE MIRIAM HOSPITAL
* The CVV2 Number is the last 3 digits on the back of your credit card, by your signature

00000075 1 SP 0.370 01
PATIENT NAME
1212 MAIN ST
ANYTOWN USA

THE MIRIAM HOSPITAL
P.O. BOX 1202
PROVIDENCE, R.I. 02901-1202

☐ Please check this box if your address or insurance information has changed and record the changes on the back of this statement

Back



Please use this space to make corrections to your address or insurance information.

Name: _____ Account No: _____ Phone: _____

Address: _____

Business Phone: _____ Employer: _____

Employer Address: _____

Insurance Company: _____ Effective Date: _____

Insurance Company Address: _____ Phone: _____

Insurance Policy or Contract No: _____ Group No: _____

Policy Holder's Name: _____ Phone: _____

Policy Holder's Date of Birth _____ Policy Holder's Gender ☐ M ☐ F Policy Holder's Social Security No: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____