


A Guide to Your Moffitt Cancer Center Statement

- A Due Date and Medical Record Number**
Who is responsible for payment and when payment is due.
- B Account Summary**
Overview of your hospital and physician charges, payments and adjustments as well as the total amount now due.
- C Amount Due**
Only those of you with active payment plans will see this breakdown of:
 - What you've agreed to pay monthly on those plans
 - What you owe on accounts not in payment plans
 - Total amount you owe this month on all accounts
- D Payment and Other Information**
How to pay your bill or contact us.
- E Payment Coupon**
Be sure to check the box for hospital and physician and indicate how much you are paying for each.
- F Hospital Activity**
This is what you owe for the hospital portion of your services including:
 - Date and Description of Services, Charges, Adjustments, Payments, and Unpaid Balance
- G Address and Insurance updates**
On the back of your payment coupon there is space to note any changes to your address or insurance.
- H Physician Activity**
This is what you owe for the physician portion of your services including:
 - Date and Description of Services, Charges, Adjustments, Payments, and Unpaid Balance

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A Statement date: 2/15/2017
 Responsible Party: SAMPLE PATIENT
 Medical Record Number: 999999
 Due Date: 04/06/2017

Thank you for choosing Moffitt Cancer Center for your health care needs.

THIS IS NOT A BILL / FOR INFORMATION ONLY

REQUEST FOR PAYMENT

B Account Summary (All Accounts)

| | |
|--------------------------------------|-----------------|
| Total Charges | \$ 4,417.00 |
| Total Insurance Payments/Adjustments | -\$4,265.00 |
| Total Patient Payments/Adjustments | -\$50.00 |
| Total Remaining Balance | \$147.00 |
| Amount Due | |
| Total Now Due Towards Payment Plan | \$50.00 |
| Total Due Non-Payment Plan Accounts | \$25.00 |
| Total Amount Now Due | \$75.00 |

Important Messages

This statement reflects both hospital and physician outstanding balances. Please promptly pay the \$ 75.00 balance or reach out to a Financial Counselor at 800-456-3434 ext 8422, Monday – Friday, 7 am – 6 pm EST to setup payment arrangements.

Payment Plan Information

If you already have a payment arrangement, then the payment plan amount due for both physician and hospital is shown in the Amount Due summary.

Any balances due for accounts not included in the payment arrangement are shown as Total Due Non-Payment Plan Accounts in the Amount Due summary. Please contact a Financial Counselor at 800-456-3434 ext 8422 to update your payment plan.

Insurance Information

Please contact a Financial Counselor at 800-456-3434 ext 8422 to report any changes to your insurance.

D Payment and Other Information

Payment methods include mail, online and over the phone.

To pay on-line, visit moffitt.org and click MyMoffitt Patient Portal.

If you need to speak with a Financial Counselor please call 800-456-3434 ext 8422, or email custservbusoff22@moffitt.org.

E MOFFITT CANCER CENTER

12902 USF Magnolia Drive Tampa, FL 33612

HLE101 999999 99999999
 SAMPLE PATIENT
 12345 Main Street
 Anywhere, FL 99999-9999

| Please indicate the payments you wish to make at this time. | | | | |
|---|------------------------------------|-----------------|----------------|-----------------------|
| Guarantor Number | Provider | Account Balance | Amount Now Due | Amount You Are Paying |
| 999999 | <input type="checkbox"/> HOSPITAL | \$ 122.00 | \$ 50.00 | \$ |
| 99999999 | <input type="checkbox"/> PHYSICIAN | \$ 25.00 | \$ 25.00 | \$ |

| ACCOUNT NAME | DUE DATE | AMOUNT NOW DUE | AMOUNT PAID |
|----------------|------------|----------------|-------------|
| SAMPLE PATIENT | 12/22/2016 | \$ 75.00 | |

Make checks payable to Moffitt Cancer Center

H. Lee Moffitt Cancer Center
 PO Box 100115
 Atlanta, GA 30384

F HOSPITAL ACTIVITY

Patient Name: **SAMPLE PATIENT** Account Number: **999999-9**

Facility Name: Moffitt Cancer Center Insurance 1: BCBS PPO Out Of State
 Date(s) of Service: 07/19/2017 Insurance 2: None on File

| Date | Description | Amount |
|-----------------------|---------------------------------|-----------------|
| 07/19/2017 | Pathology/Laboratory Services | \$3,474.00 |
| 07/19/2017 | Radiology/Imaging Services | \$602.00 |
| 07/19/2017 | Adjustment | -\$2,972.32 |
| 08/17/2017 | Insurance Payment by Blue Cross | -\$981.68 |
| Unpaid Balance | | \$122.00 |

Total Hospital Unpaid Balance \$122.00

Due Date: 09/15/2017

G CHANGE OF ADDRESS OR HEALTH INSURANCE INFORMATION

If you have health insurance or a new address, please enter the information below.

NEW ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

NEW PHONE# _____ NEW EMAIL ADDRESS _____

H PHYSICIAN ACTIVITY

Patient Name: **SAMPLE PATIENT** Patient Account Number: **999999-9**

Clinic Name: Moffitt Medical Group Type of Service: Office Visit
 Physician: Dr. DOCTOR Insurance 1: BCBS PPO OF FL
 Date(s) of Service: 07/16/2017 Insurance 2: None on File

| Date | Description | Amount |
|-----------------------|----------------------------------|----------------|
| 07/19/2017 | Office Consultation - Moderate | \$341.00 |
| 07/19/2017 | Blue Shield ERA Payment | -\$208.02 |
| 07/19/2017 | Adjustment | -\$102.98 |
| 08/17/2017 | Bank Card Payment/Line Item Post | -\$5.00 |
| Unpaid Balance | | \$25.00 |

Total Hospital Unpaid Balance \$50.00

Due Date: 09/15/2017

Total Physician Unpaid Balance \$25.00

Due Date: 09/15/2017

