Guía para entender los extractos de cuenta de Moffitt Cancer Center

A Fecha de vencimiento del pago (*Due Date*) y número de historia clínica (*Medical Record Number)*
El responsable del pago y la fecha límite antes de la cual se debe abonar el pago

B Resumen de la cuenta (*Account Summary*)
Compendio de los honorarios médicos y de las tarifas del hospital, de los pagos y ajustes realizados (*Payments/Adjustments*) y del saldo a pagar este mes (*Total Amount Now Due*)

C Importe a pagar *(Amount Due)*
Solo los pacientes acogidos a planes de pago en activo recibirán este desglose, en el que se detalla lo siguiente:
- La cantidad que se comprometió a pagar mensualmente según el plan de pago
- Lo que debe en las cuentas que no están incluidas en un plan de pago
- La cantidad total que debe este mes en todas las cuentas

D Pago y datos adicionales *(Payment and Other Information)*
Formas de pago o de comunicarse con nosotros

E Talón de pago *(Payment Coupon)*
Recuerde marcar las casillas del hospital (*Hospital*) y del médico (*Physician*) e indique cuánto pagará a cada uno de ellos.

F Servicios prestados por el hospital *(Hospital Activity)*
Esto es lo que usted debe por los servicios prestados en el hospital, y detalla:
- La fecha y la descripción de los servicios, los costos, ajustes, pagos realizados y el saldo

G Actualización de la dirección y de los datos del seguro *(Address and Insurance Updates)*
En el reverso del talón de pago encontrará espacio para escribir los cambios de dirección o de seguro.

H Servicios prestados por el médico *(Physician Activity)*
Esto es lo que debe por los servicios que recibió del médico, y detalla:
- La fecha y la descripción de los servicios, los costos, ajustes, pagos realizados y el saldo

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

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

Documento informativo; no es ninguna factura.

REQUEST FOR PAYMENT

B Account Summary (All Accounts)

Total Charges	$ 4,417.00
Total Insurance Payments/Adjustments	-$ 4,265.00
Total Patient Payments/Adjustments	-$5.00
Total Remaining Balance	$147.00

Amount Due

Total Now Due Towards Payment Plan	$ 50.00
Total Due Non-Payment Plan Accounts	$25.00
C Total Amount Now Due	$75.00

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.

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.

E

12902 USF Magnolia Drive Tampa, FL 33612

Please indicate the payments you wish to make at this time.

Guarantor Number	Provider	Account Balance	Amount Now Due	Amount You Are Paying
999999	☐ HOSPITAL	$ 122.00	$ 50.00	$
99999999	☐ 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

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

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

F **HOSPITAL ACTIVITY**

Patient Name: SAMPLE PATIENT
Facility Name: Moffitt Cancer Center
Date(s) of Service: 07/19/2017
Account Number: 999999-9
Insurance 1: BCBS PPO Out Of State
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

Due Date 09/15/2017 — Total Hospital Unpaid Balance $122.00

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
POLICY HOLDER'S NA
EFFECTIVE DATE
IF GROUP INSURANC
INSURANCE COMPAN
EMPLOYER

H **PHYSICIAN ACTIVITY**

Patient Name: SAMPLE PATIENT
Clinic Name: Moffitt Medical Group
Physician: Dr. DOCTOR
Date(s) of Service: 07/16/2017
Patient Account Number: 999999-9
Type of Service: Office Visit
Insurance 1: BCBS PPO OF FL
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

Due Date 09/15/2017 — Total Hospital Unpaid Balance $50.00

Due Date 09/15/2017 — Total Physician Unpaid Balance $25.00