



Cayuga  
Medical Center  
at Ithaca

101 DATES DRIVE • ITHACA, NEW YORK 14850-1383

Any Questions  
Regarding This  
Bill... Please Call  
607-274-4400

Office Hours:  
8:00 AM - 4:30 PM  
Monday - Friday  
Tax ID No.: 22-2325405

<b>1 Patient Name</b>			
SAUNDERS, KEVIN E			
<b>2 Service Date(s) From/Through</b>		<b>3 Statement Date</b>	<b>Page</b>
04/26/02 04/26/02		05/06/02	1

**4 This is the current insurance information on file**  
Please review and make corrections on the back of this form

Insurance Name	Policy #
1. PURE SELF PAY	431889647
2.	
3.	
4.	

**5 If paying by CREDIT CARD, please complete this section**

MASTERCARD  VISA  DISCOVER

Card # \_\_\_\_\_

Exp. Date \_\_\_\_ / \_\_\_\_ AMT. AUTHORIZED \$ \_\_\_\_\_

Signature \_\_\_\_\_

**6 CHECK/M.O.**

AMOUNT  
ENCLOSED

\$ \_\_\_\_\_

SAUNDERS, KEVIN E  
1668 TRUMANSBURG ROAD  
ITHACA NY 14850

**8 Make Checks Payable To**  
**CAYUGA MEDICAL CENTER**  
101 DATES DRIVE  
ITHACA, NEW YORK 14850-1383  
*Please Note Account Number on All Checks*

9 Account Number	10 Previous Balance	11 Charges	12 Est Ins Coverage	13 Payments/Adj's	14 Amt Due from Patient
41444894	0.00	423.75		34.66	458.41

To ensure proper credit to your account, detach top section and return with your payment

15 Account Number	16 Patient Name	17 Service Date(s)	18 Statement Dt	Page
41444894	SAUNDERS, KEVIN E	04/26/02 04/26/02	05/06/02	1

19 Date(s)	20 Description	21 Charges	22 Est Ins Coverage	23 Payments/Adj's
04/26/02	ALCOHOL URGENT	80.25		
04/26/02	DRUG SCREEN-1050; ;FROM 4441050	39.50		
04/26/02	THC-1050; ;FROM 4441050	36.25		
04/26/02	PCP-1050; ;FROM 4441050	36.25		
04/26/02	CLASS III	231.50		
05/06/02	8.18% NYS HEALTHCARE SURCHARGE			34.66
	*** SUMMARY BY SERVICE ***			
	EMERGENCY ROOM	231.50		
	LABORATORY-CLINICAL	192.25		
	RECEIPTS, ADJUSTMENTS, ETC.			34.66
<b>24 Previous Balance:</b>		<b>Column Totals:</b>		
0.00		423.75		34.66

<b>25 Amount Due from Patient:</b>	458.41
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Use this space to make corrections or additions to insurance information. Please include a photocopy of your insurance card.

Medicare # \_\_\_\_\_

New York Medicaid # \_\_\_\_\_

For other insurance, please check one and complete the area below:

- Blue Cross     Blue Shield     Commercial  
 HMO     Worker's Comp./No-fault     Other

For other insurance, please check one and complete the area below:

- Blue Cross     Blue Shield     Commercial  
 HMO     Worker's Comp./No-fault     Other

Insurance Co. Name \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder \_\_\_\_\_

Policy Holder \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Name \_\_\_\_\_

**Change of Address**

NAME	HOME TELEPHONE	EFFECTIVE DATE	
STREET ADDRESS	CITY	STATE	ZIP

**Explanation of Statement of Account**

- 1 & 16 Patient Name:** Person who received services.
- 2 & 17 Service Date(s) - From/Through:** Period of time in which services were provided; admission through discharge for inpatient stays or beginning and ending date(s) for outpatient services.
- 3 & 18 Statement Date:** Date on which this form was produced. Statement includes all transactions posted on or before this date.
- 4 Insurance information on file (#1-4):** Names of insurance companies and policy numbers on file with the billing office.
- 5 If paying by CREDIT CARD, please complete this section:**  
 Card Number: Enter credit card account number.  
 Expiration Date: Enter date on which card expires.  
 Amount Authorized: Enter amount approved for payment by card holder  
 Signature: Signature of card holder.
- 6 Check/M.O.:** Enter amount being paid by check or money order.
- 7 Responsible Party:** Name/mailling address of the person responsible for payment.
- 8 Payment Mailing Address:** When placing top section of statement in return envelope, be sure that this address is visible in the window.
- 9 & 15 Account Number:** Number used to identify the account.
- 10 & 24 Previous Balance:** Amount owed on this account as of the last statement.
- 11 & 21 Charges:** Charges incurred on the account since the last statement.
- 12 & 22 Estimated Insurance Coverage:** Amount of payment expected from insurance carrier(s) but not yet received. (Note: Coverage cannot be estimated for some insurance carriers.)
- 13 & 23 Payments/Adjustments:** Total of 1) payments by insurance and/or responsible party and 2) adjustments (such as credits, allowances or discounts) made to the account since the last statement.
- 14 & 25 Amount Due from Patient:** Amount currently due from the patient/responsible party.
- 19 Date(s):** Date of Transaction.
- 20 Description:** Description of Transaction.

- ALL BILLS ARE DUE AND PAYABLE UPON RECEIPT.
- PLEASE RETAIN A COPY OF THIS BILL. THERE IS A CHARGE FOR ADDITIONAL COPIES.
- THIS BILL SHOWS AN ESTIMATED PATIENT BALANCE. ADDITIONAL PATIENT BILLING MAY BE NECESSARY WHEN YOUR INSURANCE CARRIER(S) DO NOT PAY PORTIONS OF YOUR ESTIMATED INSURANCE COVERAGE.
- THIS STATEMENT IS FOR SERVICES RENDERED BY CAYUGA MEDICAL CENTER ONLY. YOU MAY BE BILLED FOR SERVICES PROVIDED BY OTHERS WHO MAY HAVE CONTRIBUTED TO YOUR TREATMENT OR CARE SUCH AS RADIOLOGIST, ANESTHESIOLOGISTS, ATTENDING PHYSICIAN, OR EMERGENCY ROOM PHYSICIAN.
- IF THIS IS MARKED AS A "DEMAND BILL", THERE MAY BE SUBSEQUENT CHARGES OR CREDITS WHICH WOULD CHANGE THE AMOUNT DUE AS SHOWN.
- DATE OF CHARGE MAY NOT AGREE WITH DATE OF SERVICE.
- ANY QUESTIONS REGARDING THIS BILL . . . PLEASE CALL 607-274-4400 BETWEEN 8:00 AM - 4:30 PM, MONDAY THRU FRIDAY.