Boulder Community Health

Guarantor ID	10830
Patient	Example Statement
Statement Date	08/09/2019

Balance Summary

Payments Received Since Last Statement	$ 0.00
Hospital Services Amount Due:	$ 250.00
Professional Services Amount Due:	$ 29.13
Minimum Amount Due by 08/30/19	**$ 279.13**

Payments received after this date may not be reflected on your next statement.
Account Detail is on the following pages.

MyBCH
Sign up or log in to MyBCH to view statements and pay your bill. Visit **my.bch.org** to learn more.

MyBCH Authorization Code: M4HTF-J4CPF-9JK9C

Scan QR code for quick access

Important Information

Thank you for choosing Boulder Community Health for your health care services. The amount due is now your responsibility as of the statement date and does not include any services that are still pending payment from an insurance carrier. Payment in full is expected by the due date unless other acceptable arrangements are made.

You may also receive additional bills from non-BCH physicians.

Customer Service
For Inquiries/Changes/Updates
Call (303) 415-5300; Monday through Friday 7:30am-4:30 pm, except Thursday 11:00am-4:30pm
Para ayuda en Español llame al numero (303) 415-4758.

Financial Assistance
Boulder Community Health has many financial assistance options available for qualified patients, including discounted care for the uninsured and extended payment programs. To obtain a free copy of BCH's financial assistance policy, plain language summary, or application please visit **bch.org**. Customer Service Representatives are available to provide information regarding the programs that may be available to you by calling 303-415-5300.
Para obtener infomacion acerca de la asistencia financiera, porfavor visite **www.bch.org** o 'llame al (303) 415-4758.

Please see reverse side for account detail.

Please detach the bottom portion and return with your payment in the enclosed envelope. **Make checks payable to Boulder Community Health**. Allow 5 days if mailing your payment.

Guarantor ID	10830
Due Date	08/30/19
Minimum Amount Due	**$ 279.13**
Amount I Am Paying	$

Credit Card ☐ VISA ☐ MasterCard ☐ DISCOVER ☐ AMERICAN EXPRESS

Card # ____________ ____________ ____________ ____________

Cardholder Name ____________________________ Exp Date ______

Signature ____

EXAMPLE STATEMENT
1234 STATEMENT SAMPLE WAY
BOULDER, CO 80304

Boulder Community Health
5450 Western Ave
Boulder, CO 80301

Call us at (303) 415-5300 for billing inquiries.

Pay this bill online at **my.bch.org**.

Boulder Community Health

Guarantor ID 10830
Patient Example Statement
Statement Date 08/09/2019

Statement of Services

	Date of Service	Description of Services	Charge	Insurance Payments	Adjustments	Patient Payments	Amount You Owe
Professional Services	08/09/19	99214 Office Visit, Est Pt, Moderate Complexity	$163.00				
Account # 1050060432 Elizabeth Lycett, MD Boulder Community Health	08/09/19	81003 Urinalysis, Auto, W/O Scope	$10.00				
		08/09/19 Insurance Payment - United Healthcare		$-116.52			
		08/09/19 Payor Contractual Allowance - United Healthcare			$-19.19		
		08/09/19 Payor Contractual Allowance - United Healthcare			$-8.16		$29.13
Total			**$173.00**	**$-116.52**	**$-27.35**	**$0.00**	**$29.13**
Hospital Services	08/09/19	Emergency Room - General Classification	$1,143.00				
Account # 1050060449 Boulder Community Health		08/09/19 Insurance Payment - United Healthcare		$-306.00			
		08/09/19 Payor Contractual Allowance - United Healthcare			$-587.00		$250.00
Total			**$1,143.00**	**$-306.00**	**$-587.00**	**$0.00**	**$250.00**
Total All Services			**$1,316.00**	**$-422.52**	**$-614.35**	**$0.00**	**$279.13**

Hospital Balance	Professional Balance	Total Account Balance
$250.00	**$29.13**	**$279.13**

Change of Address or Insurance Coverage

1. Address Change

Street Address

____

City State Zip Code Area Code + Telephone Number

____

2. Medicare ☐ Primary Ins. ☐ Secondary Ins. ☐ Managed Medicare

ID # ____________

Part A - Hospital Insurance ☐ Effective Date ____________

Part B - Physician Insurance ☐ Effective Date ____________

3. Medicaid ☐ Primary Ins. ☐ Secondary Ins. ☐ Managed Medicaid

Name on Card ____________________ Effective Date ________

a) State ID # ____________

4. Other Coverage Primary

Subscriber's Name/DOB ____________________

Relationship to Patient ____________ Effective Date ____________

Insurance Co. Name and Phone ____________________

Insurance Co. Street Address ____________________

Insurance Co. City/State/Zip ____________________

ID # ______________ Group # ______________

5. Other Coverage Secondary

Subscriber's Name/DOB ____________________

Relationship to Patient ____________ Effective Date ____________

Insurance Co. Name and Phone ____________________

Insurance Co. Street Address ____________________

Insurance Co. City/State/Zip ____________________

ID # ______________ Group # ______________

*** * * If possible, please enclose a front & back copy of your Insurance ID Card with this change * * ***