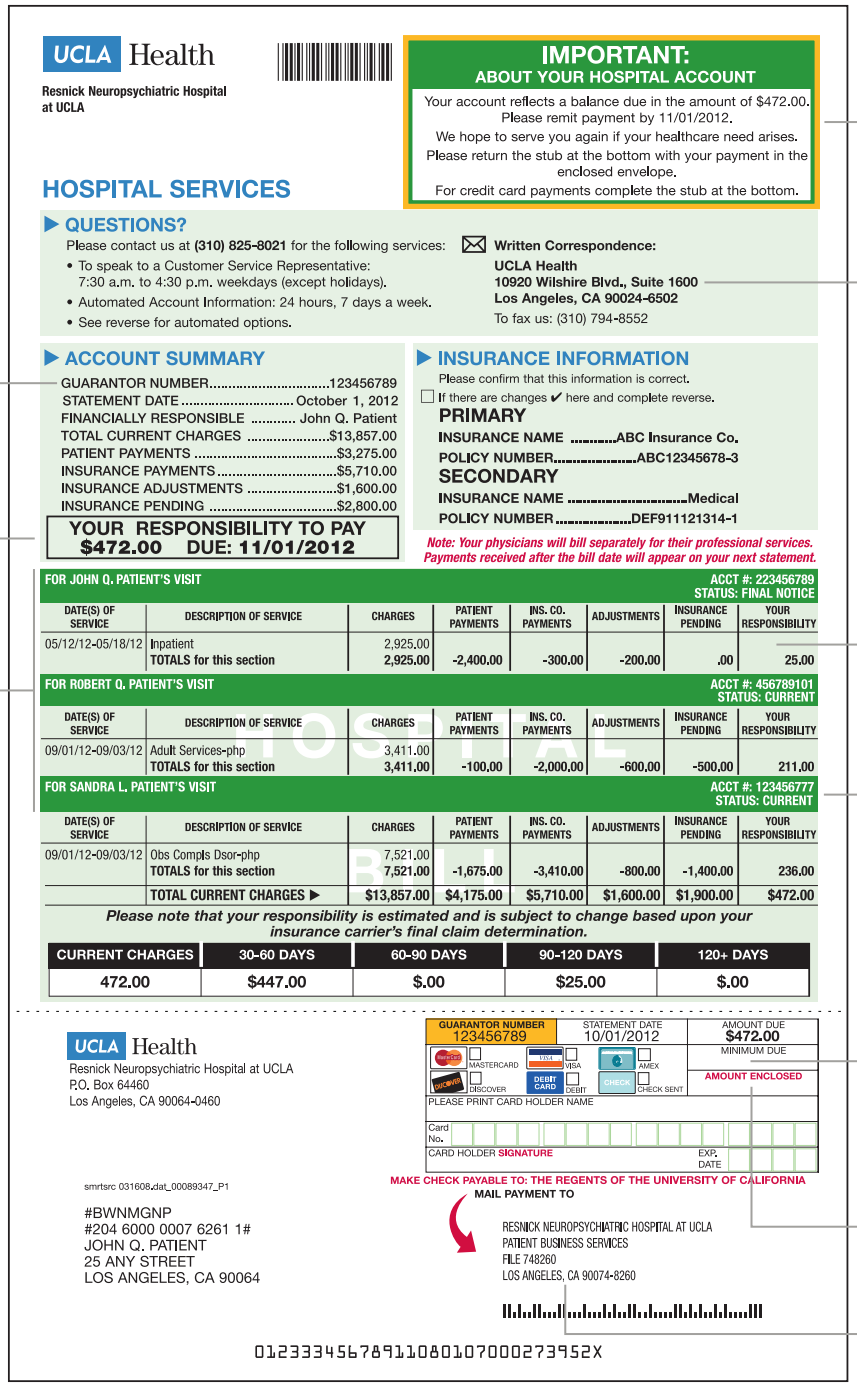
We've made your statement easier to read



UCLA Health

Resnick Neuropsychiatric Hospital at UCLA

IMPORTANT:
ABOUT YOUR HOSPITAL ACCOUNT

Your account reflects a balance due in the amount of $472.00. Please remit payment by 11/01/2012.
We hope to serve you again if your healthcare need arises.
Please return the stub at the bottom with your payment in the enclosed envelope.
For credit card payments complete the stub at the bottom.

Please read important messages regarding your account status.

HOSPITAL SERVICES

QUESTIONS?

Please contact us at **(310) 825-8021** for the following services:

- To speak to a Customer Service Representative: 7:30 a.m. to 4:30 p.m. weekdays (except holidays).
- Automated Account Information: 24 hours, 7 days a week.
- See reverse for automated options.

Written Correspondence:
UCLA Health
10920 Wilshire Blvd., Suite 1600
Los Angeles, CA 90024-6502
To fax us: (310) 794-8552

Where to write to us or send special information.

ACCOUNT SUMMARY

Your new guarantor number.

GUARANTOR NUMBER	123456789
STATEMENT DATE	October 1, 2012
FINANCIALLY RESPONSIBLE	John Q. Patient
TOTAL CURRENT CHARGES	$13,857.00
PATIENT PAYMENTS	$3,275.00
INSURANCE PAYMENTS	$5,710.00
INSURANCE ADJUSTMENTS	$1,600.00
INSURANCE PENDING	$2,800.00

Payment expected and date due.

YOUR RESPONSIBILITY TO PAY $472.00 DUE: 11/01/2012

INSURANCE INFORMATION

Please confirm that this information is correct.
☐ If there are changes ✔ here and complete reverse.

PRIMARY
INSURANCE NAME .....ABC Insurance Co.
POLICY NUMBER.....ABC12345678-3

SECONDARY
INSURANCE NAME .....Medical
POLICY NUMBER.....DEF911121314-1

Note: Your physicians will bill separately for their professional services. Payments received after the bill date will appear on your next statement.

FOR JOHN Q. PATIENT'S VISIT — ACCT #: 223456789 STATUS: FINAL NOTICE

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	CHARGES	PATIENT PAYMENTS	INS. CO. PAYMENTS	ADJUSTMENTS	INSURANCE PENDING	YOUR RESPONSIBILITY
05/12/12-05/18/12	Inpatient	2,925.00					
	TOTALS for this section	**2,925.00**	**-2,400.00**	**-300.00**	**-200.00**	**.00**	**25.00**

Multiple family members are listed on one statement.

FOR ROBERT Q. PATIENT'S VISIT — ACCT #: 456789101 STATUS: CURRENT

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	CHARGES	PATIENT PAYMENTS	INS. CO. PAYMENTS	ADJUSTMENTS	INSURANCE PENDING	YOUR RESPONSIBILITY
09/01/12-09/03/12	Adult Services-php	3,411.00					
	TOTALS for this section	**3,411.00**	**-100.00**	**-2,000.00**	**-600.00**	**-500.00**	**211.00**

This column is the amount you must pay after payments and adjustments.

FOR SANDRA L. PATIENT'S VISIT — ACCT #: 123456777 STATUS: CURRENT

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	CHARGES	PATIENT PAYMENTS	INS. CO. PAYMENTS	ADJUSTMENTS	INSURANCE PENDING	YOUR RESPONSIBILITY
09/01/12-09/03/12	Obs Compls Dsor-php	7,521.00					
	TOTALS for this section	**7,521.00**	**-1,675.00**	**-3,410.00**	**-800.00**	**-1,400.00**	**236.00**
	TOTAL CURRENT CHARGES ▶	**$13,857.00**	**$4,175.00**	**$5,710.00**	**$1,600.00**	**$1,900.00**	**$472.00**

Your account status.

Please note that your responsibility is estimated and is subject to change based upon your insurance carrier's final claim determination.

CURRENT CHARGES	30-60 DAYS	60-90 DAYS	90-120 DAYS	120+ DAYS
472.00	$447.00	$.00	$25.00	$.00

The back of your statement has important information for you.

You may find your answers there.

UCLA Health
Resnick Neuropsychiatric Hospital at UCLA
P.O. Box 64460
Los Angeles, CA 90064-0460

GUARANTOR NUMBER	STATEMENT DATE	AMOUNT DUE
123456789	10/01/2012	$472.00

MASTERCARD ☐ VISA ☐ AMEX ☐ DISCOVER ☐ DEBIT CARD ☐ CHECK SENT ☐

MINIMUM DUE

AMOUNT ENCLOSED

If you are on a payment plan your agreed payment will appear here.

PLEASE PRINT CARD HOLDER NAME

Card No.

CARD HOLDER SIGNATURE EXP. DATE

Write in the amount of your check or money order.

smrtsrc 031608.dat_00089347_P1

#BWNMGNP
#204 6000 0007 6261 1#
JOHN Q. PATIENT
25 ANY STREET
LOS ANGELES, CA 90064

MAKE CHECK PAYABLE TO: THE REGENTS OF THE UNIVERSITY OF CALIFORNIA
MAIL PAYMENT TO

RESNICK NEUROPSYCHIATRIC HOSPITAL AT UCLA
PATIENT BUSINESS SERVICES
FILE 748260
LOS ANGELES, CA 90074-8260

Send payments here.

01233345678911080107000273952X

Frequently Asked Questions

Q: What is a facility fee?

A: A facility fee is for the use of our clinics and ancillary services.

Q: Does my hospital bill include doctor's fees?

A: Physicians bill separately for their charges. UCLA Physician Support Services/Medical Group can be reached at (310) 301-8877.

Q: What happens if my insurance denies the claim?

A: A statement will be mailed to you advising you how much you owe. You should also receive an Explanation of Benefits (EOB) or a denial notification from your Health Plan.

If your health plan is Medi-Cal, Medicare, HMO or Worker Compensation, you will only receive a bill when your claim is denied or your health plan identifies a patient responsibility.

Q: What if I cannot pay in full or have a financial hardship?

A: We understand you may not be able to pay the entire balance. A reasonable payment arrangement must be made with one of our customer service representatives in order to hold your account from becoming delinquent. Patients who require assistance in meeting their financial obligations for the services received at UCLA Health may apply for financial assistance.

Please contact one our customer service representatives at (310) 825-8021 to assist you with your financial situation.

For more information, go to uclahealth.org/yourbill