

## We've made your statement easier to read

## Frequently Asked Questions

Two hospitals on one bill.

Your new guarantor number.

Payment expected and date due.

Multiple family members are listed on one statement.

The back of your statement has important information for you. You may find your answers there.

Please read important messages regarding your account status.

Where to write to us or send special information.


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

Your account status.


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

Write in the amount of your check or money order.

Send payments here.



**UCLA Health**  
Ronald Reagan UCLA Medical Center  
Santa Monica-UCLA Medical Center and Orthopaedic Hospital



**IMPORTANT: ABOUT YOUR HOSPITAL ACCOUNT**

Your account reflects a balance due in the amount of \$236.00. 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.

**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

**ACCOUNT SUMMARY**

GUARANTOR NUMBER.....123456789  
STATEMENT DATE.....October 1, 2012  
FINANCIALLY RESPONSIBLE.....John Q. Patient  
TOTAL CURRENT CHARGES.....\$6,336.00  
PATIENT PAYMENTS.....\$1,600.00  
INSURANCE PAYMENTS.....\$2,300.00  
INSURANCE ADJUSTMENTS.....\$800.00  
INSURANCE PENDING.....\$1,400.00

**YOUR RESPONSIBILITY TO PAY**  
**\$236.00 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 TO UCLA HEALTH AT RONALD REAGAN UCLA MEDICAL CENTER** ACCT #: 223456789 STATUS: PAST DUE

| DATE(S) OF SERVICE | DESCRIPTION OF SERVICE         | CHARGES         | PATIENT PAYMENTS | INS. CO. PAYMENTS | ADJUSTMENTS    | INSURANCE PENDING | YOUR RESPONSIBILITY |
|--------------------|--------------------------------|-----------------|------------------|-------------------|----------------|-------------------|---------------------|
| 07/12/12-08/18/12  | Emergency Room                 | 2,470.00        |                  |                   |                |                   |                     |
| 07/12/12           | Sodium Chloride Inj 0.9% 10 ml | 60.00           |                  |                   |                |                   |                     |
| 07/12/12           | Blood Count Manual Diff Wbc    | 70.00           |                  |                   |                |                   |                     |
| 07/13/12           | Cbc & Platelet Count           | 60.00           |                  |                   |                |                   |                     |
| 07/14/12           | Prothrombin Time               | 65.00           |                  |                   |                |                   |                     |
|                    | <b>TOTALS for this section</b> | <b>2,725.00</b> | <b>-1,500.00</b> | <b>-300.00</b>    | <b>-200.00</b> | <b>-700.00</b>    | <b>25.00</b>        |


**FOR SALLY R. PATIENT'S VISIT TO UCLA HEALTH AT RONALD REAGAN UCLA MEDICAL CENTER** ACCT #: 123456999 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  | Ct Abdomen W&wo Contrast       | 1,480.00        |                  |                   |                |                   |                     |
| 09/02/12           | Ct Pelvis W/contrast           | 1,451.00        |                  |                   |                |                   |                     |
|                    | <b>TOTALS for this section</b> | <b>2,931.00</b> | <b>-100.00</b>   | <b>-2,000.00</b>  | <b>-600.00</b> | <b>-20.00</b>     | <b>211.00</b>       |

**FOR MARY R. PATIENT'S VISIT TO SANTA MONICA-UCLA MEDICAL CENTER AND ORTHOPAEDIC HOSPITAL** ACCT #: 456789101 STATUS: CURRENT

| DATE(S) OF SERVICE | DESCRIPTION OF SERVICE         | CHARGES           | PATIENT PAYMENTS | INS. CO. PAYMENTS | ADJUSTMENTS     | INSURANCE PENDING | YOUR RESPONSIBILITY |
|--------------------|--------------------------------|-------------------|------------------|-------------------|-----------------|-------------------|---------------------|
| 08/01/12-08/01/12  | MRI                            | 710.00            |                  |                   |                 |                   |                     |
|                    | <b>TOTALS for this section</b> | <b>710.00</b>     | <b>.00</b>       | <b>-710.00</b>    | <b>.00</b>      | <b>.00</b>        | <b>.00</b>          |
|                    | <b>TOTAL CURRENT CHARGES</b>   | <b>\$6,366.00</b> | <b>1,600.00</b>  | <b>\$3,010.00</b> | <b>\$800.00</b> | <b>\$720.00</b>   | <b>\$236.00</b>     |

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**UCLA Health**  
Ronald Reagan UCLA Medical Center  
Santa Monica-UCLA Medical Center and Orthopaedic Hospital  
P.O. Box 64460  
Los Angeles, CA 90064-0460

smrtsc 031608,dal\_00089347\_P1

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

**GUARANTOR NUMBER**  
123456789

**STATEMENT DATE**  
10/01/2012

**AMOUNT DUE**  
\$236.00

**MINIMUM DUE**  
\$0.00

**AMOUNT ENCLOSED**  
\$0.00

**PLEASE PRINT CARD HOLDER NAME**  
Card No. \_\_\_\_\_

**CARD HOLDER SIGNATURE**  
\_\_\_\_\_

**EXPIRATION DATE**  
\_\_\_\_/\_\_\_\_/\_\_\_\_

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

RONALD REAGAN UCLA MEDICAL CENTER  
SANTA MONICA-UCLA MEDICAL CENTER AND ORTHOPAEDIC HOSPITAL  
PATIENT BUSINESS SERVICES  
FILE 748260  
LOS ANGELES, CA 90074-8260

01233345678911080107000273952X

### 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**