

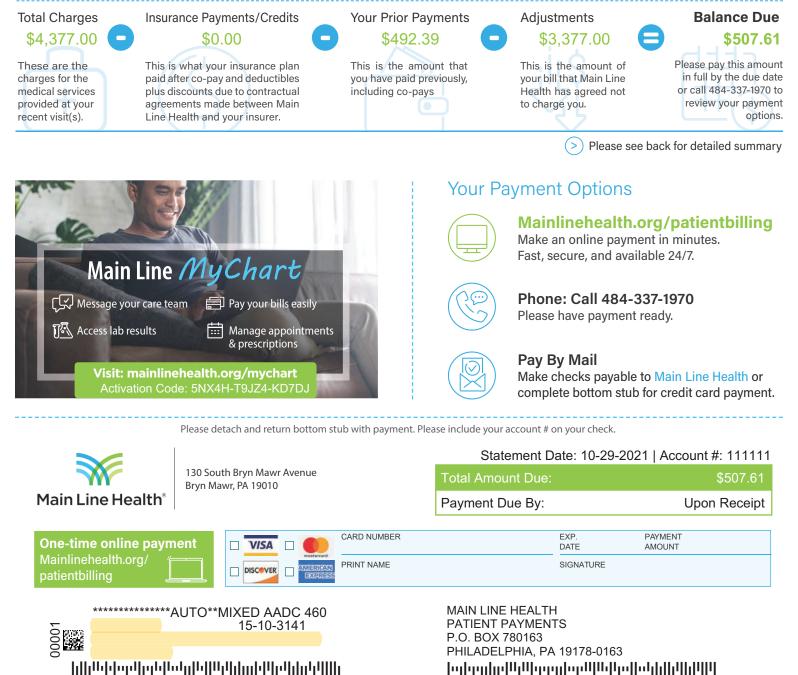
Questions About Your Account? Phone: 484-337-1970 Hours: Monday - Friday: 8am - 6pm Visit: mainlinehealth.org/patientbilling



| Main Line Health Account Summary

Account Number: 1111111 | Statement Date: 10-29-2021

Thank you for choosing Main Line Health for your medical needs. Our records indicate that your insurance has processed your claim and the balance due is your responsibility. Please remit your balance of **\$507.61**. If you have been billed for more than one visit, your payment will be applied to the oldest amount due before it is applied to the most recent bill, unless otherwise specified. Payments received after the billing cycle will appear on your next statement.





Total Amount You Owe:

>

\$507.61

Due Upon Receipt

NEW BALANCES	Patient Name:	Guarantor #111111
Hospital Charges		
Account # 2101338050 Service Date: 6/20/20	21 - 6/20/2021	
Paoli Hospital		Amount
Total Charges		\$4,377.00
Insurance Payments & Credits		\$0.00
Adjustments		-\$3,377.00
Patient Payments		-\$492.39
Balance		\$507.61
	Overall Patient Responsibility for Hospital Servi	ces \$507.61

Financial Assistance

Charity care and Financial Assistance is available for those who qualify. Visit: **mainlinehealth.org/assistance**. La Politica de atención caritativa y de asistencia de la linea principal de salud está ubicada en: **mainlinehealth.org/assistance**.

PLEASE COMPLETE IF THERE ARE ERRORS OR CHANGES IN ADDRESS OR INSURANCE INFORMATION

Responsible Person's Name		Home Phone Number	Work	Work Phone Number		Mail Address		
Address		City		S	State ZI		/ARITAL STATUS INGLE /ARRIED	□ SEPARATED □ DIVORCED □ WIDOWED
Primary Insurance Coverage	Policy Holder (Subscriber) Name	Subscriber Birth Date	Effective Date		Subscriber ID Number		Group/Plan Number	
	Insurance Company Name	Insurance Company Ad	nce Company Address City State			ZIP		
	Employer Name	Employer Phone	Plan Name				ionship of Patient to Subscriber .F □ SPOUSE □ CHILD □ OTHER	
	Policy Holder (Subscriber) Name	Subscriber Birth Date			Subscriber II	O Number	Group/Plan Number	
Secondary Insurance Coverage	Insurance Company Name	Insurance Company Ad	ance Company Address		City		State ZIP	
corenage	Employer Name	Employer Phone	Plan Name			Relationship of P □ SELF □ SPO	f Patient to Subscriber OUSE □CHILD □OTHER	