IU Health
250 N. Shadeland Ave.
Indianapolis, IN 46219

Indiana University Health

Statement date: 11/4/2020
Patient name: Sample A Sample
Account number: 99999999
Due date: 11/27/2020

Patient's name and account number

207 1 SP 0.500

207

Sample A Sample
123 Sample St
Sample IN, 99999

The statement is addressed to the patient's or guarantor's billing address

The Account Summary provides you with a quick, easy-to understand overview of what you owe and when payment is due.

Request for payment

Account summary

Total patient responsibility	$$$.$$
Minimum due by 11/27/2020	**$$$.$$**

Payments made after last statement due date may not be reflected in this statement.

Account status: Good standing

Payment plan

X months interest free @ $$$.$$/month, expiring January 1, 2021. Contact us to extend terms.

Insurance information

If there is a change in your insurance, please visit us immediately at MyIUHealth.org to update it or call customer service at 877.668.5621.

More details about your account will be displayed on the other side of the statement.

Visit Us Online at www.iuhealth.org to:

- Sign up for My IU Health
- Access your account
- Pay your bill
- View your statement

Please Note:
Your consolidated statement only includes services billed by Indiana University Health Revenue Cycle Services for certain facilities and physician groups. You may still receive additional statements from providers who are not part of this billing service.

Payment and other information

Pay your bill online at **MyIUHealth.org**.

Pay your bill using our automated service:
IU Health Customer Service
8 am - 7 pm Monday through Friday
Tenemos asistencia disponible en Español.
T 317.612.2754 Indianapolis
T 1.888.IUHEALTH Toll free

Pay by mail – return completed coupon by mail

Financial assistance is available to eligible patients per Indiana University Health Financial Assistance Policy. A plain language summary of this policy is located on the back of this page or at IUHealth.org.

Statement ID: 99999

Statement date: November 4, 2020

Confirm patient information

ACCT # 99999999

Sample A Sample
123 Sample St
Sample IN, 99999

❑ Please check here if your address or insurance has changed. Please indicate changes on the back of this page.

Payment due date:	Pay this amount:	Amount enclosed:
11/27/2020	$$$.$$	

Check payments – Please make checks payable to IU Health and write your account number on the check.

Credit card payments: ❑ ❑ ❑

Card number: _____ Exp. date: _____

Cardholder name: _____

Cardholder signature: _____

IU HEALTH
PO BOX 4374
CHICAGO, IL 60680-437

If you'd prefer to mail your payment, please mail to this address to ensure timely credit to your account.

IU Health Financial Assistance Policy

Financial assistance is available to qualifying uninsured and underinsured patients receiving care at an IU Health hospital location. If you are uninsured, you will receive a discount and be billed only the amount that is generally billed to patients with insurance coverage at that IU Health hospital facility. If you receive a medically necessary service your insurance does not cover, you may receive a discount similar to the discount received by uninsured patients. If you enter into a pre-negotiated agreement with IU Health for payment of services, you will not qualify for financial assistance under this policy.

If you are an Indiana resident, as defined in the IU Health Financial Assistance Policy, who receives care via the emergency department, direct admission from a physician s office, or transfer from another hospital, you may be eligible to receive additional assistance if paying your medical bills is a financial hardship and you apply. If you meet the Federal Poverty Level (FPL) criteria below, you may be eligible for financial assistance up to the full amount of your medical bill.

# of Adults in Household	# of Dependents in Household	FPL Income Threshold
1+	0	200%
2+	1+	250%
1	1+	300%

If your income is above these levels but the amount you owe is more than 20% of your annual household income, you may apply for assistance and be eligible for a discount to 20% of your annual income.

No patient approved for financial assistance due to financial hardship will be charged more than the amounts generally billed to patients who have insurance coverage for similar care provided at the respective IU Health hospital facility where the patient received services.

Complete Financial Assistance Applications should include all required attachments and information in order to be considered. IU Health may determine that you qualify for additional assistance and aid you in the completion of an application for state assistance programs including Medicaid and the Healthy Indiana Plan. If financial assistance is approved, you will receive written notification and an updated statement with your reduced balance.

The IU Health Financial Assistance Application, Financial Assistance Policy and a summary of IU Health financial assistance are available for free at the registration desk at any IU Health location or online at www.iuhealth.org/financialassistance. The policy, application, and this plain language summary are available to download or print in English as well as the following languages: Arabic, Burmese, Hakha Chin, Karen, Mandarin Chinese, and Spanish.

To learn more about available financial assistance, the application process, request an enrollment appointment with a certified Financial Navigator, or request a free copy of the application materials by mail, please contact us at 1-888-531-3004 or seek assistance at the registration desk at any IU Health location.

Please complete and return if your address or insurance has changed.

Change of insurance information

Name:_____ Account #: 36770493
Relationship to patient:_____
Date of birth:_____ SSN:_____
Policy name:_____
Policy #:_____ Group #:_____
Network name:_____
Insurance company phone #:_____
Insurance company name:_____
Insurance company address:_____
_____
Employers name:_____
Employers address:_____
_____
Employment status:_____

Change of address information

Name:_____
Address:_____
_____
City:_____State:_____
ZIP:_____ Country:_____
Phone:_____ Business phone:_____

Communications concerning bankruptcy notifications or disputed medical bills must be clearly marked as such and sent to:

IU Health Patient Financial Services
250 N. Shadeland Ave.
Indianapolis, IN 46219

Please do not send payments to this address.

Patient: Sample A Sample

Visit date	Invoice #	Provider name/service location	Total charges	Insurance payments/ adjustments	Patient payments/ adjustments	Amount you owe
06/27/19	999999	IU Health Ball Memorial Hospital CAT Scan	$$$.$$	-$$$.$$	$$$.$$	$$$.$$

Total summary amount: $$$.$$