



**Wheaton Franciscan Healthcare**  
Covenant Medical Center | Sartori Memorial Hospital | Mercy Hospital

**1**

Wheaton Franciscan Healthcare  
Correspondence Address  
PO Box 5995  
Peoria, IL 61601-5995



Reference Number: 1234567-001

Please check box if below address is incorrect or insurance information has changed. Please indicate changes on reverse side.

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JOHN Q PUBLIC  
101 1ST AVE  
WATERLOO, IA 50701



IF PAYING BY MASTERCARD, VISA, OR DISCOVER, FILL OUT BELOW  
CHECK CARD USING FOR PAYMENT

MASTERCARD   
 VISA   
 DISCOVER

|                              |                             |                       |
|------------------------------|-----------------------------|-----------------------|
| <b>14</b> CARD NUMBER        | CVV CODE                    | AMOUNT                |
| SIGNATURE                    |                             | EXP. DATE             |
| STATEMENT DATE<br>07/20/2010 | PAY THIS AMOUNT<br>\$340.00 | ACCOUNT #<br>87654321 |

Date Due: 08/19/2010

|                       |    |
|-----------------------|----|
| SHOW AMOUNT PAID HERE | \$ |
|-----------------------|----|

**Submit payment to:**

Wheaton Franciscan Healthcare- IA  
Payment Processing Center  
PO Box 5435 Dept 0019  
Carol Stream, IL 60197-5435

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Please detach and return top portion with your payment.

**STATEMENT OF ACCOUNT**

Statement Date: 07/20/2010    Mercy Hospital|Sartori Memorial Hospital|



**Wheaton Franciscan Healthcare**

Statement Number: 87654321 **2** Covenant Medical Center|Covenant Home Medical

Covenant Medical Center | Sartori Memorial Hospital | Mercy Hospital

| PATIENT NAME           |                   | REFERENCE NUMBER  |                   | LOCATION        |                                    |
|------------------------|-------------------|-------------------|-------------------|-----------------|------------------------------------|
| SERVICE DATE           | ORIGINAL BALANCE  | INSURANCE PAID    | ADJUSTMENT        | PATIENT PAID    | BALANCE DUE                        |
| <b>4</b> JOHN Q PUBLIC |                   |                   | 1234567-001       |                 | SARTORI PHYSICAL THERAPY <b>6</b>  |
| <b>5</b> 04/01/2010    | <b>7</b> \$903.00 | <b>8</b> \$251.86 | <b>9</b> \$511.14 | <b>10</b> \$.00 | <b>11</b> \$140.00                 |
| <b>4</b> JANE R PUBLIC |                   |                   | 1234567-002       |                 | MERCY HOSPITAL OUTPATIENT <b>6</b> |
| <b>5</b> 05/04/2010    | \$582.00          | \$152.32          | \$329.68          | \$.00           | \$100.00                           |
| <b>4</b> JEFF T PUBLIC |                   |                   | 1234567-003       |                 | COVENANT EMERGENCY <b>6</b>        |
| <b>5</b> 06/01/2010    | \$663.00          | \$176.36          | \$386.64          | \$.00           | \$100.00                           |

Financial assistance is available to those who qualify. Please call the number below for more information.

**MESSAGES**

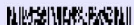
Thank you for choosing us for your health care needs. Please make full payment or contact us at 319-272-7020 or toll free (866)867-0178 to make payment arrangements. You may also pay on-line at <https://covhealth.ixt.com/QuickPayAccount.aspx>.

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Wheaton Franciscan Healthcare- IA  
Payment Processing Center  
PO Box 5435 Dept 0019  
Carol Stream, IL 60197-5435

(319) 272-7020  
(866) 867-0178 tollfree

**TOTAL AMOUNT DUE**  
**\$340.00** **13**



## Understanding Your Billing Statement

1. **Facility Name** – Identifies Wheaton Franciscan Healthcare as the healthcare provider.
2. **Guarantor Account Number** - The account number to the guarantor for the services.
3. **Address** - The guarantor name and address appears here.
4. **Patient Name** - The name of the person that received services.
5. **Service Date** - Date of service for this line item.
6. **Place of Service**- Service location for this line item and date of service. This also indicates the major service category.
7. **Original Balance:** This is the total of the charges for this date of service.
8. **Insurance Paid:** This is the amount your insurance paid for the service(s) on this date.
9. **Insurance Disallow:** This is the contractual or other adjustment made to the original balance
10. **Patient Paid:** This is the amount you paid for services on this date. This will reflect the copay or pre-payment amount.
11. **Balance Due** - Represents the remaining balance due on this service.
12. **Message** - This is additional information to assist in payment of service, including who to call with any questions.
13. **Guarantor Due** - Total outstanding debt assigned to this guarantor.
14. **Credit Card Payment** - If paying by credit card, use this area to complete the necessary information, including type of credit card, card number, expiration date, amount you are paying, and signature. We accept Visa, MasterCard and Discover.
15. **Mailing Address** - Where payment can be sent to. If paying in cash, please come to the office to pay in person at the hospital cashier office located on the first floor or off the lobby in the Waterloo Covenant Clinic office. Please do not send cash in the mail.