HOW TO READ YOUR STATEMENT

- Physician Group Name The name of the group of physicians who interpreted and documented the medical imaging exams for the patient.
- Physician Group Billing Address The address of the billing and billing office of the physicians
- Online Payment Option To pay by credit card please visit our secure online patient payment portal at xraybill.com. Most major credit cards accepted.
- Provider Number and Account Number Account to which payment will be applied. The letters and numbers before the dash are the Provider Number. The numbers after the dash are the Account Number.
- Payment Amount The amount due from you for this statement.
- Billing Office Phone Number To make a payment or to ask questions about this bill, use the number listed.
- Electronic Statement Delivery You may register at this site to receive future statements via secure email.
- Name and address of Guarantor The name and address of the person responsible for paying this bill who may or may not be the patient.
- Payment Mailing Address Please use this address to mail payment.
- Date The date the radiology services were received.
- CPT Code The medical procedure code number for the services provided.
- Service Description A description of the medical services provided to the patient referenced by the CPT Code.
- Payment Lists any payments received on this account during the current billing period.
- Amount Balance due for each service received.
- Statement Date Date statement was printed.
- Messages Any messages about your account will appear here.



DETACH TOP PORTION AND RETURN WITH PAYMENT IN ENCLOSED ENVELOP

10	DATE 11	CPT CODE	12 SERVICE DESCRIPTION	13	PAYMENT	14	AMOUNT
	12/07/18	74177/26	CT ABD AND PELV W/ CONTRAST				\$235.00
			Patient: Mary A. Patient				
			Primary BLUE CROSS BLUE SHIE	Primary BLUE CROSS BLUE SHIELD billed on 12/20/18			
				Claim 1 Total:			\$235.00
	12/07/18	74018/26	ABDOMEN, 1 VIEW				\$33.00
	Patient: Mary A. Patient						
			Primary BLUE CROSS BLUE SHIE	Primary BLUE CROSS BLUE SHIELD billed on 12/20/18			
				Claim 2	Total:		\$33.00
	12/08/18	74018/26	ABDOMEN, 1 VIEW				\$33.00
			Patient: Mary A. Patient	Primary BLUE CROSS BLUE SHIELD billed on 12/20/18			
			Primary BLUE CROSS BLUE SHIE				
				Claim 3	Total:		\$33.00
	12/12/18	71045/26	CHEST XRAY, 1 VIEW				\$33.00
			Patient: Mary A. Patient				
			Primary BLUE CROSS BLUE SHIE	Primary BLUE CROSS BLUE SHIELD billed on 12/20/18			
				Claim 4	Total:		\$33.00



Account Information

Statement Date: 12/31/2018 Account: ABC-12345678 Mary A. Patient Patient:

\$334.00 This amount is vour responsibility To pay your balance of \$334.00 please select one:

- 1. Visit Xraybill.com to pay by credit card or contact us by email.
- 2. Mail top portion of this statement along with your payment
- 3. Call our office to pay by phone at 800-318-5578

Your insurance has denied payment on the above services. Contact them for the reason of denial. The balance due is your responsibility. Please remit.

Radiology Imaging Doctors PO Box 1234 Anytown USA 12345-1234 800-318-5578