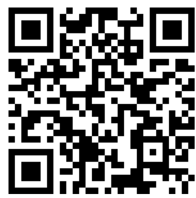
Hannibal Regional

STATEMENT



Visit our Website: www.hannibalregional.org/online-bill-pay

Radiologist's Message: Thank you for allowing our Radiologists to be a part of your care! You may also receive an additional bill from the hospital for their portion of these services.

SUMMARY OF CHARGES

DUE DATE	LAST PAYMENT DATE	PATIENT	ACCOUNT#	STATEMENT ID
07/15/21	05/05/2021	LASTNAME, FIRSTNAME	49185	1231725228

DATE	CODE	DESCRIPTION OF SERVICE	AMOUNT
04/15/21	76775	ECOGRAPHY RETROPERITONEA	$116.00
		PAYMENTS/ADJUSTMENTS	$87.55

SAMPLE

YOUR INSURANCE HAS APPLIED THIS CHARGE TO YOUR YEARLY DEDUCTIBLE. THE BALANCE DUE IS YOUR RESPONSIBILITY.

STATEMENT DATE	SERVICE LOCATION	PRIMARY INSURANCE	SECONDARY INSURANCE
06/24/2021	HANNIBAL REGIONAL HOSPITAL	MERITAIN HEALTH	

For Billing Questions: **(866) 917-3598**

PLEASE PAY THIS AMOUNT $28.45

Patient Services Available At Our Website: www.hannibalregional.org/online-bill-pay

- Pay Your Bills Online
- Update Your Insurance
- Setup A Payment Plan
- View Itemized Statement
- Update Your Address
- Update Your Personal Information
- Register For Electronic Statements
- Various Patient Forms
- Ask A Question

DETACH HERE AND RETURN THIS BOTTOM PORTION WITH YOUR PAYMENT USING THE RETURN ENVELOPE ENCLOSED

Hannibal Regional Hospital Radiology
P.O. Box 3190
Dublin, OH 43016

FORWARDING SERVICE REQUESTED

MasterCard VISA AMERICAN EXPRESS DISCOVER CareCredit

Visit our website: www.hannibalregional.org/online-bill-pay
Statement ID: 1231725228

STATEMENT DATE	ACCOUNT #	PAY THIS AMOUNT
06/24/2021	49185	$28.45
DUE DATE	AMOUNT ENCLOSED	
07/15/21		

Still have a Question?
Please have your insurance card ready and call **(866) 917-3598**

163687-2-14835613

163687 - 2

MAKE CHECK PAYABLE AND REMIT TO:

FIRSTNAME LASTNAME
1 MAIN STREET
HANNIBAL MO 63401

Hannibal Regional Hospital Radiology
P.O. Box 371863
Pittsburgh, PA 15250-7863

0001231725228000022218100000028450003

FOR HOSPITAL OR OTHER FACILITY PATIENTS

YOU COULD RECEIVE TWO OR MORE BILLS FOR SERVICES PROVIDED

TOTAL DIAGNOSTIC OR TREATMENT COSTS

PHYSICIAN OR PROVIDER'S FEE

HOSPITAL CHARGES OR OTHER FACILITY

This statement is not a duplicate charge, but a separation of the facility and physician or provider's fees. These services were provided while you were under our care, or at the request of your other physicians or providers.

Your bill from the facility may include a separate charge for use of its equipment, supplies, and technical personnel.

You may also receive bills from other physicians or providers who were involved with your care if you were a patient in a hospital or other facility.

If you have any questions concerning your bill, please call our office and we will be happy to assist you.

IF YOU REQUIRE ASSISTANCE, YOU MAY CONTACT OUR OFFICE AT THE PHONE NUMBER ON THE REVERSE SIDE.

102457

"DETACH HERE AND RETURN BELOW STUB"

IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

PATIENT INFORMATION

Your Name (Last, First, Middle Initial)	Date of Birth	
Address		
City	State	Zip
Telephone ( )		
Social Security #		
Employer's Name	Telephone ( )	
Employer's Address		
City	State	Zip
Please Indicate if Applicable: ☐ AUTO ACCIDENT ☐ WORKER'S COMPENSATION	Date of Injury	

INSURANCE INFORMATION

Your **PRIMARY** Insurance Company's Name		
Primary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number	Group Plan Number	
Your **SECONDARY** Insurance Company's Name		
Secondary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number	Group Plan Number	