Actual Chemo Treatment Bill

EMORY
UNIVERSITY
HOSPITAL
MIDTOWN

Mail Processing Center
P.O. Box 3475
Toledo, OH 43607-0475

RETURN SERVICE REQUESTED

003097
0101

Patient Name: [redacted]

Please write your account number on your check.
Make check payable to Emory University Hospital Midtown.

CHECK CARD USING FOR PAYMENT
MASTERCARD DISCOVER VISA AMERICAN EXPRESS
CARD NUMBER | SECURITY CODE
SIGNATURE | EXP. DATE

DUE DATE	STATEMENT DATE	ACCT. #
09/19/2017	08/30/2017	[redacted]

AMOUNT DUE: Insurance Pending
SHOW AMOUNT PAID HERE $

654573C (PC1)

[redacted]

EMORY UNIVERSITY HOSPITAL MIDTOWN
PO BOX 660827
Mailstop #22222222
DALLAS, TX 75266-0827

[redacted]

☐ Check box if above address is incorrect and indicate change(s) on reverse side.

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

Your Statement

Thank you for choosing Emory Healthcare. This statement reflects a summary of charges from your visit. THIS IS NOT A BILL.

If other medical providers or physicians helped in your care, you will receive additional bills from them. Please check the information below. If your insurance is not listed below or is incorrect, please contact us IMMEDIATELY.

Account Summary

Statement Date	08/30/2017
Date of Service	07/25/2017
Account Number	[redacted]
Type of Service	Infusion Recurring visit
Total Charges	84,283.20
Primary Insurance Payments Received	0.00
Secondary Insurance Payments Received	0.00
Patient Payments Received	0.00
Adjustment	0.00
This is your balance	**Insurance Pending**

Contact Us

Please call the HOSPITAL Customer Service Department at **404-686-7041** or **800-827-7041** weekdays between the hours of 8:30 am and 4:30 pm. When inquiring about this account or when informing us of changes to personal information (insurance coverage, address, etc.), please indicate the Patient Account Number and Date of Service.

PAY BY PHONE: 855-851-7193

PAY ONLINE at:
https://emoryuh.ixt.com

A simple and easy way to access your updated

Preemie Baby Bill

BlueCross BlueShield

Explanation of Benefits

634

THIS IS NOT A BILL

INDEPENDENCE BLUE CROSS
1901 MARKET STREET
FEP SG-7
PHILADELPHIA, PA. 19103-1480
(215)241-4400

EXPLANATION OF BENEFITS AT A GLANCE

We Sent Check To: MAIN LINE HOSPITALS, INC - BRYN MAW
Patient Name:
Dates of Service: 12/05/2018 - 03/02/2019
You Owe the Provider: $875.00

ID Number:
Claim Number:
Claim Paid On: 03/20/2019
Claim Received On: 03/07/2019
Claim Processed On: 03/13/2019
Patient Acct No:

Provider: MAIN LINE HOSPITALS, INC - BRYN MAW
Type: PREFERRED PROVIDER

Dates of Service: 12/05/2018 - 03/02/2019

Type of Service	Submitted Charges	Plan Allowance	Remark Codes	Deduct	Coinsurance Or Copay	Medicare/ Other Ins.	What We Paid	You Owe the Provider
MEDICAL CARE	312,696.00	472,832.00	110		875.00		471,957.00	875.00
			610					
MEDICAL CARE	267,660.00		634					
PRESCRIPTION DRUG	65,099.00		634					
PRESCRIPTION DRUG	648.00		634					
MEDICAL EQUIP/SUPPLY	8,260.00		634					
DIAGNOSTIC LAB TEST	431.00		634					
DIAGNOSTIC LAB TEST	7,597.00		634					
DIAGNOSTIC LAB TEST	1,320.00		634					
DIAGNOSTIC LAB TEST	814.00		634					
DIAGNOSTIC LAB TEST	255.00		634					
XRAY, TECHNICAL CHRG	10,452.00		634					
SURGERY	932.00		634					
WHOLE BLOOD	53.00		634					
WHOLE BLOOD	1,349.00		634					
XRAY, TECHNICAL CHRG	3,018.00		634					
MEDICAL CARE	149,886.00		634					
OCCUPATIONAL THERAPY	2,800.00		634					
OCCUPATIONAL THERAPY	445.00		634					
DIAGNOSTIC LAB TEST	2,451.00		634					
MEDICAL CARE	1,055.00		634					
PRESCRIPTION DRUG	1,870.00		634					
PRESCRIPTION DRUG	6,132.00		634					
MEDICAL CARE	360.00		634					
MEDICAL CARE	98,142.00		634					
MEDICAL CARE	26,766.00		634					
TOTALS:	970,491.00	472,832.00		0.00	875.00	0.00	471,957.00	875.00

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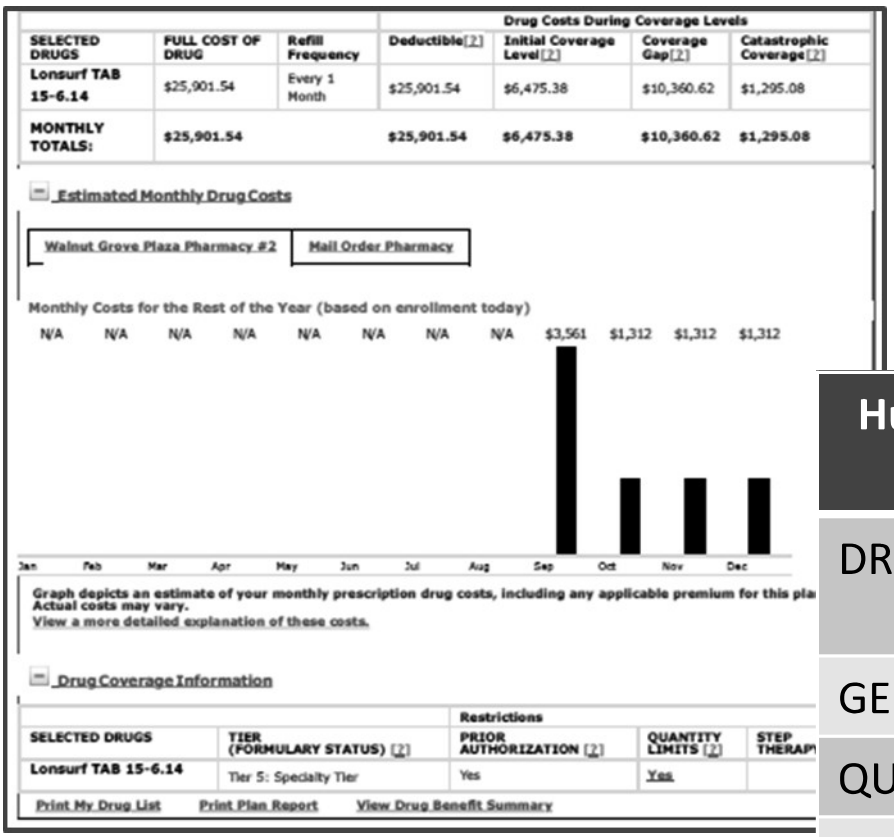
RX Catastrophic Costs

An MA - PDP Illustration



SELECTED DRUGS	FULL COST OF DRUG	Refill Frequency	Drug Costs During Coverage Levels: Deductible[?]	Initial Coverage Level[?]	Coverage Gap[?]	Catastrophic Coverage[?]
Lonsurf TAB 15-6.14	$25,901.54	Every 1 Month	$25,901.54	$6,475.38	$10,360.62	$1,295.08
MONTHLY TOTALS:	$25,901.54		$25,901.54	$6,475.38	$10,360.62	$1,295.08

Estimated Monthly Drug Costs

Walnut Grove Plaza Pharmacy #2 | Mail Order Pharmacy

Monthly Costs for the Rest of the Year (based on enrollment today)

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$3,561	$1,312	$1,312	$1,312

Graph depicts an estimate of your monthly prescription drug costs, including any applicable premium for this pla
Actual costs may vary.
View a more detailed explanation of these costs.

Drug Coverage Information

SELECTED DRUGS	TIER (FORMULARY STATUS) [?]	Restrictions: PRIOR AUTHORIZATION [?]	QUANTITY LIMITS [?]	STEP THERAP
Lonsurf TAB 15-6.14	Tier 5: Specialty Tier	Yes	Yes	

Print My Drug List | Print Plan Report | View Drug Benefit Summary

Humana Walmart RX Plan (PDP)	
DRUG NAME:	**Lonsurf TAB:** Tier 5
GENERIC OPT:	No
QUANTITY:	180
REFILL:	Every 1 Month
MONTHLY:	$25,901.54
DEDUCTIBLE:	$25,901.54
MONTHLY COST IN CATA-STROPHIC / 5% COVERAGE PERIOD:	$1,295.08