[redacted]

Henry Ford Health System
PO Box 553920
Detroit, MI 48255-3920

[redacted]

[redacted]

Statement Date: June 05, 2019
Patient: Brianna Snitchler
Guarantor ID: [redacted]

Amount Due:

$3,357.52

Payment is due by:
06/25/19

At Henry Ford, we put "each patient first", and are committed to providing our patients with quality healthcare and the best Henry Ford experience.

Thank you for choosing Henry Ford Health System. This statement reflects the balance that you owe for services received at one, or more, of our Henry Ford Health System facilities. The detail of the services rendered and the amount you owe are included on the attached pages.

Important Messages Regarding Your Accounts

Please submit payment of $3,357.52 by June 25, 2019 or call us at 1-800-999-5829 if you would like to make payment arrangements.

Paperless Billing	Pay Online	Pay by Phone
PAPERLESS BILLING *Go to henryford.com/MyChart to sign up for paperless billing.*	MyChart Go to henryford.com/MyChart Activation code: [redacted] Or Use MyChart to Pay as a Guest	24 Hour Automated Service 1-800-999-5829 Representatives are available Monday - Thursday: 7am - 6pm Friday: 7am - 5pm

Patient	Guarantor ID	Due Date	Amount Due	Amount Paid
Brianna Snitchler	[redacted]	06/25/19	$3,357.52	$

* Make checks payable to Henry Ford Health System
* Please include your Guarantor ID on the check
* Enclose this payment stub with your payment
* Please see reverse side to provide updated information

Henry Ford Health System
PO BOX 553920
Detroit, MI 48255-3920
[redacted]

Card Holder Name	
Card Number	Exp Date
Signature	

[redacted]

Henry Ford Health System
PO Box 553920
Detroit, MI 48255-3920

General Information

Identification Numbers:
Guarantor ID - represents the identification number of the person responsible for payment of the services rendered. This number is used for financial and billing correspondence.
MRN (medical record number) - represents the unique identification number of the patient.
Account Number - represents a specific encounter, visit, or hospital stay.

Charges:
Medical Services - Charges for hospital or medical facility services such as procedures, diagnostic tests, lab, therapy, supplies, and drugs.
Physician Services - Charges for professional services rendered by physicians or other medical practitioners.

Insurance & Patient Activity:
Insurance Activity - Payments made by your insurance to Henry Ford Health System, and contractual adjustments that reflect the difference between the charge and the negotiated payment made by your insurance.
Patient Activity - Payments made by the guarantor to Henry Ford Health System, and discounts applied to the patient's account.

Explanation of Amount You Owe:
Deductible - The amount you are responsible to pay before your insurance will pay. Annual amount determined by your insurance plan.
Co-insurance - The portion of the payment that your insurance requires you to pay after meeting your annual deductible.
Co-payment - A fixed amount you are responsible to pay for a specific covered service. Co-payments are set by your insurance plan and will vary based on the type of service.
Non-covered services - A service that is not covered by your insurance, or is not a benefit of your specific insurance plan.

If your personal or insurance information has changed, please indicate changes below.

PERSONAL INFORMATION			INSURANCE INFORMATION		
NAME		DATE OF BIRTH	PRIMARY INSURANCE COMPANY		
ADDRESS			PRIMARY INSURANCE COMPANY ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
PHONE			POLICY HOLDER NAME		DATE OF BIRTH
EMAIL ADDRESS			POLICY HOLDER ID NUMBER		
EMPLOYER ADDRESS			GROUP PLAN NUMBER		
EMPLOYER CITY	EMPLOYER STATE	EMPLOYER ZIP CODE			

[redacted]

Henry Ford Health System
PO Box 553920
Detroit, MI 48255-3920

[redacted]

Statement Summary	
Previous Balance	$418.97
New Services	$3,912.76
New Payments/Adjustments	$-974.21
Total Amount You Owe	$3,357.52
Payments Not Applied	$0.00
Amount Due by 06/25/19	**$3,357.52**

New Accounts

Date	Description	Charges	Insurance Activity	Patient Activity	Amount You Owe
4/17/2019 - Physician Services at ST HGTS RAD ULTRASOUND				Acct # [redacted]	
04/17/19	US, ABDOMEN LIMITED	107.00			
05/08/19	United Healthcare Payments		0.00		
	Deductible: 38.66				
	Insurance Adjustments		-68.34		
	Amount You Owe				**$38.66**
05/10/19 - Medical Services at HFHN HENRY FORD HOSPITAL				Acct # [redacted]	
	Laboratory	161.00			
05/30/19	United Healthcare Payments		0.00		
	Deductible: 44.97				
	Insurance Adjustments		-116.03		
	Amount You Owe				**$44.97**
05/13/19 - Medical Services at HFHN HENRY FORD HOSPITAL				Acct # [redacted]	
	Pharmacy	104.76			
	Medical/Surgical Supplies and Devices	159.00			
	Laboratory Pathological	170.00			
	Operating Room Services	2,170.00			
	Other Imaging Services	471.00			
	Pulmonary Function	98.00			
06/03/19	United Healthcare Payments		-512.32		
	Deductible: 2,440.87				
	Coinsurance: 219.57				
	Amount You Owe				**$2,660.44**

Henry Ford Health System
PO Box 553920
Detroit, MI 48255-3920

Date	Description	Charges	Insurance Activity	Patient Activity	Amount You Owe
5/13/2019 - Physician Services at HFH RAD ULTRASOUND				Acct # [redacted]	
05/13/19	SONO GUIDE NEEDLE BIOPSY	117.00			
05/13/19	SURG PATH,LEVEL IV	165.00			
05/13/19	NEEDLE BIOPSY,MUSCLE	190.00			
06/05/19	United Healthcare Payments		-27.26		
	Coinsurance: 11.68				
	Insurance Adjustments		-250.26		
	Amount You Owe				**$194.48**
	Totals for New Accounts	**3,912.76**	**-974.21**	**0.00**	**$2,938.55**

Accounts from Previous Statements

Date	Description	Charges	Insurance Activity	Patient Activity	Amount You Owe
04/17/19 - Medical Services at HFHN STERLING HEIGHTS				Acct # [redacted]	
	Other Imaging Services	506.00			
05/06/19	United Healthcare Payments		0.00		
	Deductible: 418.97				
	Insurance Adjustments		-87.03		
	Amount You Owe				**$418.97**
	Totals for Accounts from Previous Statements	**506.00**	**-87.03**	**0.00**	**$418.97**

Total Amount Owed: **$3,357.52**

Amount Due by *6/25/2019*: **$3,357.52**

We are committed to providing information to patients who may need financial help to pay their medical bills. For more information or to obtain a free copy of our Patient Financial Assistance Program Policy or Application, please call the telephone number or visit the website listed below.

Nuestro compromiso es proporcionar información a los pacientes que podrían necesitar ayuda financiera para pagar sus facturas médicas. Para obtener más información o para obtener una copia de la solicitud o de la política de nuestro Programa de Ayuda Financiera al Paciente, llame al número de teléfono o visite el sitio web que se indican a continuación.

نحن ملتزمون بتقديم المعلومات للمرضى الذين قد يحتاجون لمساعدة مالية لسداد الفواتير الخاصة بهم. ولمزيد من المعلومات حول سياسة برنامج تقديم المساعدات المالية للمرضى أو الطلب، أو الحصول على نسخة مجانية منهما، يرجى الاتصال بالرقم الهاتفي أو زيارة الموقع الإلكتروني المدرج أدناه.

Telephone: 1-800-999-5829 **Website:** www.henryford.com/FinancialAssistance

[redacted]

Henry Ford Health System
PO Box 553920
Detroit, MI 48255-3920

[redacted]

Henry Ford Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Let the health care team know if you need an interpreter. Henry Ford Health System provides language assistance services free of charge. For questions or additional information, email CommunicationAccess@hfhs.org

Henry Ford Health System cumple con las leyes federales vigentes de derechos civiles y no discrimina con base en la raza, el color, el país de origen, la edad, la discapacidad o el sexo. Informe al equipo de atención médica si necesita un intérprete. Henry Ford Health System ofrece servicios de asistencia de idioma sin costo alguno. Si tiene alguna pregunta o necesita información adicional, envíe un correo electrónico a CommunicationAccess@hfhs.org

يمتثل نظام Henry Ford Health System لقوانين الحقوق المدنية الفيدرالية السارية ولا يُمَيِّز على أساس العرق أو اللون أو الأصل القومي أو السن أو الإعاقة أو الجنس. يُرجى إخطار فريق الرعاية الصحية إذا كنت تحتاج إلى مترجم فوري. يوفر نظام Henry Ford Health System خدمات المساعدة اللغوية مجانًا. للاستفسارات أو المعلومات الإضافية، أرسل بريدًا إلكترونيًا إلى CommunicationAccess@hfhs.org

Website: www.henryford.com/visitors/expect/communication

HENRY FORD HEALTH SYSTEM

Brianna Snitchler
[redacted]

Guarantor ID: [redacted]

Thank you for choosing Henry Ford Health System as your healthcare provider. Taking care of you is our #1 priority. At Henry Ford, we put "each patient first" and are committed to providing our patients with quality health care and the best Henry Ford Experience.

This is not a bill. This is an itemization of services rendered for :

HFMC St Hgts Radiology Ultrasound
Patient: Snitchler,Brianna
Hospital Account [redacted]

Admission Date: 04/17/19
Discharge Date: 04/17/19

Hospital Charges

Date	Rev Code	Procedure Code	Description	Qty	Amount
04/17/19	0402	402767050	US ABDOMEN LIMITED	1	506.00
Total hospital charges:					**506.00**

Hospital Payments and Adjustments

Date	Description	Amount
	United Healthcare Payments and Adjustments	87.03
Total hospital payments and adjustments:		**87.03**

Total Account Balance	**$418.97**
Total Self-pay Balance	**$418.97**

Please call our Customer Service Department at 1-800-999-5829 if you have questions regarding this information.

HENRY FORD HEALTH SYSTEM

Brianna Snitchler
[redacted]

Guarantor ID: [redacted]

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This is not a bill. This is an itemization of services rendered for :

HFMC St Hgts Radiology Ultrasound
Patient: Snitchler,Brianna
Hospital Account [redacted]

Admission Date: 04/17/19
Discharge Date: 04/17/19

Professional Charges

Service Date	Service Provider	Px Description	Px Code	Transaction Amount
04/17/2019	KIRSCH, AARON JOSHUA [H553728]	US, ABDOMEN LIMITED	76705	$107.00

Total professional charges: 107.00

Professional Payments and Adjustments

Date	Description	Amount
	United Healthcare Payments and Adjustments	68.34

Total professional payments and adjustments: 68.34

Total Account Balance	**$38.66**
Total Self-pay Balance	**$38.66**

Please call our Customer Service Department at 1-800-999-5829 if you have questions regarding this information.

HENRY FORD HEALTH SYSTEM

Brianna Snitchler
[redacted]

Guarantor ID: [redacted]

Thank you for choosing Henry Ford Health System as your healthcare provider. Taking care of you is our #1 priority. At Henry Ford, we put "each patient first" and are committed to providing our patients with quality health care and the best Henry Ford Experience.

This is not a bill. This is an itemization of services rendered for :

HFH Radiology Interventional
Patient: Snitchler,Brianna
Hospital Account [redacted]

Admission Date: 05/13/19
Discharge Date: 05/13/19

Hospital Charges

Date	Rev Code	Procedure Code	Description	Qty	Amount
05/13/19	0402	402769420	ULSO GUIDED NEEDLE PLACEMENT	1	471.00
05/13/19	0361	361000TR2	TRMT RM RADIOLOGY LEVEL 2	1	2,170.00
05/13/19	0270	270005503	BIOPSY TRAY LVL 2	1	108.00
05/13/19	0270	270000301	MISCELLANEOUS SUPPLY LEVEL 1 COST $10-$24.99	1	51.00
05/13/19	0250	272001186	HB DEVICE BIOPSY L11 CM OD18 GA LATEX FREE	1	104.76
05/13/19	0460	460000024	PULSE OX; O2 SAT MULTI DET	1	98.00
05/13/19	0312	310000037	LAB LEVEL IV SURG GROSS & MICR	1	170.00
Total hospital charges:					**3,172.76**

Hospital Payments and Adjustments

Date	Description	Amount
	United Healthcare Payments and Adjustments	512.32
Total hospital payments and adjustments:		**512.32**

Total Account Balance **$2,660.44**

Total Self-pay Balance **$2,660.44**

Please call our Customer Service Department at 1-800-999-5829 if you have questions regarding this information.

HENRY FORD HEALTH SYSTEM

Brianna Snitchler
[redacted]

Guarantor ID: [redacted]

Thank you for choosing Henry Ford Health System as your healthcare provider. Taking care of you is our #1 priority. At Henry Ford, we put "each patient first" and are committed to providing our patients with quality health care and the best Henry Ford Experience.

This is not a bill. This is an itemization of services rendered for :

Hfh Pathology Op Lab
Patient: Snitchler,Brianna
Hospital Account [redacted]

Admission Date: 05/10/19
Discharge Date: 05/10/19

Hospital Charges

Date	Rev Code	Procedure Code	Description	Qty	Amount
05/10/19	0305	300000380	LAB CBC AUTO & AUTO DIFF WBC	1	40.00
05/10/19	0305	300000440	LAB PROTHROMBIN TIME	1	20.00
05/10/19	0305	300000448	LAB PART THROMBOPLASTIN (PTT)	1	45.00
05/10/19	0301	300000003	LAB BASIC METABOLIC PANEL (TOT CA)	1	44.00
05/10/19	0300	300000775	VENIPUNCTURE	1	12.00
Total hospital charges:					**161.00**

Hospital Payments and Adjustments

Date	Description	Amount
	United Healthcare Payments and Adjustments	116.03
Total hospital payments and adjustments:		**116.03**

Total Account Balance	**$44.97**
Total Self-pay Balance	**$44.97**

Please call our Customer Service Department at 1-800-999-5829 if you have questions regarding this information.

HENRY FORD HEALTH SYSTEM

Brianna Snitchler
[redacted]

Guarantor ID: [redacted]

Thank you for choosing Henry Ford Health System as your healthcare provider. Taking care of you is our #1 priority. At Henry Ford, we put "each patient first" and are committed to providing our patients with quality health care and the best Henry Ford Experience.

This is not a bill. This is an itemization of services rendered for :

HFH Radiology Interventional
Patient: Snitchler,Brianna
Hospital Account [redacted]

Admission Date: 05/13/19
Discharge Date: 05/13/19

Professional Charges

Service Date	Service Provider	Px Description	Px Code	Transaction Amount
05/13/2019	KIRSCH, AARON JOSHUA [H553728]	NEEDLE BIOPSY,MUSCLE	20206	$190.00
05/13/2019	KIRSCH, AARON JOSHUA [H553728]	SONO GUIDE NEEDLE BIOPSY	76942	$117.00
05/13/2019	RAOUFI, MOHAMMAD [H11180]	SURG PATH,LEVEL IV	88305	$165.00
Total professional charges:				**472.00**

Professional Payments and Adjustments

Date	Description	Amount
	United Healthcare Payments and Adjustments	277.52
Total professional payments and adjustments:		**277.52**

Total Account Balance **$194.48**

Total Self-pay Balance **$194.48**

Please call our Customer Service Department at 1-800-999-5829 if you have questions regarding this information.

[redacted]

UnitedHealthcare®

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

[redacted]

May 30, 2019

[redacted]

Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary

Detailed claim information is located on the following page(s).

Dollar Amount	Description
$4,020.98	**Amount Billed** The amount your provider charged for services provided to you.
$523.30	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$539.58	**Your Plan Paid** The money your health benefit plan paid.
$2,958.10	**Total amount you owe the provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non covered charges. This amount does not include any payments made to the subscriber*. If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. * When coordination of benefits applies, this amount will include payments made to the subscriber.

[redacted]

UnitedHealthcare

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
Phone: 1-866-270-5311

May 30, 2019

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

Claim Detail for BRIANNA SNITCHLER

[redacted] [redacted] [redacted]

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
05/10/2019	LABORATORY SERVICES	UG	$149.00	$104.03	$44.97	$0.00	$44.97	$0.00	$0.00	$0.00	$44.97
Claim Total:			**$149.00**	**$104.03**	**$44.97**	**$0.00**	**$44.97**	**$0.00**	**$0.00**	**$0.00**	**$44.97**

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

Claim Detail for BRIANNA SNITCHLER

[redacted] [redacted] [redacted]

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
05/13/2019	SURGERY	UG	$190.00	$51.79	$138.21	$0.00	$138.21	$0.00	$0.00	$0.00	$138.21
05/13/2019	RADIOLOGY SERVICES	UG	$117.00	$72.41	$44.59	$0.00	$44.59	$0.00	$0.00	$0.00	$44.59
Claim Total:			**$307.00**	**$124.20**	**$182.80**	**$0.00**	**$182.80**	**$0.00**	**$0.00**	**$0.00**	**$182.80**

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

[redacted]

UnitedHealthcare

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
Phone: 1-866-270-5311

May 30, 2019

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

[redacted]

Claim Detail for BRIANNA SNITCHLER

[redacted]

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
05/13/2019	OUTPATIENT SERVICES	UG	$1,002.76	$0.00	$1,002.76	$0.00	$1,002.76	$0.00	$0.00	$0.00	$1,002.76
05/13/2019	OUTPATIENT SERVICES	D2	$2,170.00	$0.00	$2,170.00	$512.32	$1,438.11	$0.00	$219.57	$0.00	$1,657.68
Claim Total:			**$3,172.76**	**$0.00**	**$3,172.76**	**$512.32**	**$2,440.87**	**$0.00**	**$219.57**	**$0.00**	**$2,660.44**

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

[redacted]

UnitedHealthcare

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
Phone: 1-866-270-5311

May 30, 2019

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

Claim Detail for BRIANNA SNITCHLER

[redacted] [redacted] [redacted]

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
05/13/2019	LABORATORY SERVICES	D1	$165.00	$126.06	$38.94	$27.26	$0.00	$0.00	$11.68	$0.00	$11.68
Claim Total:			**$165.00**	**$126.06**	**$38.94**	**$27.26**	**$0.00**	**$0.00**	**$11.68**	**$0.00**	**$11.68**

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

Notes*

D1 - THE PLAN DISCOUNT SHOWN IS YOUR SAVINGS FOR USING A NETWORK PROVIDER. THE AMOUNT YOU OWE MAY INCLUDE YOUR COPAY, COINSURANCE, DEDUCTIBLE, PLUS ANY AMOUNT DUE IF YOU'VE REACHED YOUR BENEFIT LIMIT ON A COVERED SERVICE.

D2 - THE PLAN DISCOUNT SHOWN IS YOUR SAVINGS FOR USING A NETWORK PROVIDER. THE AMOUNT YOU OWE MAY INCLUDE YOUR COPAY, COINSURANCE, DEDUCTIBLE, PLUS ANY AMOUNT DUE IF YOU'VE REACHED YOUR BENEFIT LIMIT ON A COVERED SERVICE.

UG - THE PLAN DISCOUNT SHOWN IS YOUR SAVINGS FOR USING A NETWORK PROVIDER. YOU HAVE NOT MET YOUR DEDUCTIBLE AND OWE THE AMOUNT SHOWN.

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: UnitedHealthcare Appeals, P.O. Box 30432, Salt Lake City, UT 84130-0432. The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review no later than 30 days after we receive your request for review.

If your plan is governed by ERISA, you may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

You or your authorized representative, such as a family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above.

You may request copies (free of charge) of information relevant to your claim by contacting us at the above address.

Availability of Consumer Assistance/Ombudsman Services