Meridian Valley Health System

Patient Financial Services · P.O. Box 55120, Fairhaven, ST 58027-5120
Billing 1-855-555-0130 (Mon–Fri 8:00 a.m.–6:00 p.m.) · Fax 1-855-555-0139
mvhs.example/billing · Language assistance and TTY 711 available at no cost

ITEMIZED PATIENT STATEMENT

Statement date
June 4, 2027
Guarantor account
MVH-2027-0093412
Encounter
ENC-4418-220671
Amount due
$1,019.68 by July 4, 2027

Itemized Statement of Account

Hospital charges for the outpatient encounter of April 18, 2027 · Statement 2 of this account cycle

THIS IS A BILL — AND EVERY LINE ON IT CAN BE CHECKED

Compare this statement against the Explanation of Benefits your plan mailed on May 6, 2027 before you pay. If any line does not match, call 1-855-555-0130 and the account will be held while we review it.

GUARANTOR	PATIENT	FACILITY	ENCOUNTER TYPE
Rowan D. Whitaker	**Rowan D. Whitaker (self)**	**Meridian Valley Medical Center — Fairhaven campus**	**Emergency department, converted to observation**
HEALTH PLAN	MEMBER ID / GROUP	CLAIM NUMBER	PLAN EOB DATE
Cascade Ridge Health Plan · Cascade Select PPO 2500	**CRH 771 204 336 00 · Group G-22104**	**2027-1188-44207**	**May 6, 2027**

ITEMIZED SERVICE LINES FOR ENCOUNTER ENC-4418-220671

SERVICE DATE	REV. CODE	CPT / HCPCS	DESCRIPTION	QTY	UNIT CHARGE	TOTAL CHARGE
04/18/2027	0450	99284	Emergency department visit, level 4	1	$1,842.00	$1,842.00
04/18/2027	0320	71046	Radiologic examination, chest, 2 views	1	$364.00	$364.00
04/18/2027	0350	74177	CT, abdomen and pelvis, with contrast	1	$2,918.00	$2,918.00
04/18/2027	0636	Q9967	Low osmolar contrast material, 100 mL	1	$186.00	$186.00
04/18/2027	0300	80053	Comprehensive metabolic panel	1	$214.00	$214.00
04/18/2027	0300	85025	Complete blood count with differential	1	$128.00	$128.00
04/18/2027	0301	84484	Troponin, quantitative (serial)	2	$96.00	$192.00
04/18/2027	0636	J2405	Injection, ondansetron hydrochloride, per 1 mg	4	$18.00	$72.00
04/18/2027	0270	—	Medical and surgical supplies, intravenous start kit	1	$68.00	$68.00
04/18/2027	0762	—	Observation room, per hour	8	$148.00	$1,184.00
04/18/2027	0730	93005	Electrocardiogram, tracing only, without interpretation	1	$172.00	$172.00
04/18/2027	0940	—	Pharmacy, self-administered oral medications	3	$24.00	$72.00
			TOTAL CHARGES — 12 SERVICE LINES	**25**		**$7,412.00**

Quantity is the number of units billed, not the number of medications or tests ordered. The quantity column totals 25 units across 12 lines. A charge is our standard published price before any insurance contract is applied; almost no one pays the charge column.

CHARGES ROLLED UP BY CATEGORY

CHARGE CATEGORY	REVENUE CODES	LINES	SUBTOTAL
Emergency department services	0450	1	$1,842.00
Observation services	0762	1	$1,184.00
Diagnostic imaging	0320, 0350	2	$3,282.00
Laboratory	0300, 0301	3	$534.00
Drugs and contrast material	0636	2	$258.00
Supplies	0270	1	$68.00
Cardiac diagnostics	0730	1	$172.00
Self-administered pharmacy	0940	1	$72.00
Total charges		**12**	**$7,412.00**

This rollup is the same $7,412.00 shown above, grouped a different way. Use it to find a department quickly; use the line detail to check an individual charge.

ACCOUNT AGING AS OF JUNE 4, 2027

AGING BUCKET	AMOUNT
Current (0–30 days)	$0.00
31–60 days	$1,019.68
61–90 days	$0.00
91–120 days	$0.00
Over 120 days	$0.00
Total account balance	**$1,019.68**

Aging runs from the date of service, April 18, 2027 — 47 days as of this statement. An account is never referred to an outside collection agency while a documented dispute or a complete financial assistance application is pending.

HOW YOUR BALANCE WAS CALCULATED, STEP BY STEP

#	CALCULATION	AMOUNT
1	Total charges for this encounter — the twelve service lines listed above	$7,412.00
2	Less: charges not submitted to your plan — self-administered oral medications, revenue code 0940	–$72.00
3	Charges submitted to Cascade Ridge Health Plan on 04/24/2027 under claim 2027-1188-44207	$7,340.00
4	Less: contractual adjustment required by our participating-provider agreement — written off permanently and never billed to you	–$4,151.60
5	Plan allowed amount — the most the plan and you together owe for these lines	$3,188.40
6	Less: plan payment received 05/11/2027, remittance check 4471028	–$1,590.72
7	Your cost share of the allowed amount — deductible $1,200.00 plus coinsurance $397.68, which is 20% of the $1,988.40 remaining after the deductible	$1,597.68
8	Plus: non-covered charges carried down from step 2	$72.00
9	Your total responsibility for this encounter (step 7 plus step 8)	$1,669.68
10	Less: payment made at the time of service 04/18/2027, receipt 88-40213	–$250.00
11	Less: online payment posted 05/12/2027, confirmation 2027-05-12-77410	–$400.00
12	Plus: balance forward from the statement dated 05/05/2027 — no prior unpaid balance	$0.00
	AMOUNT DUE BY JULY 4, 2027	**$1,019.68**

Each step begins with the result of the step before it. A minus sign means the amount reduces what you owe. Step 4 is the single largest number on this page and you never owe any part of it — it is the discount our contract with Cascade Ridge Health Plan requires us to absorb.

RECONCILING THIS STATEMENT AGAINST YOUR EXPLANATION OF BENEFITS

LINE ON YOUR EOB DATED MAY 6, 2027	EOB AMOUNT	WHERE THE SAME NUMBER APPEARS HERE	STATEMENT AMOUNT	MATCH
Amount billed	$7,340.00	Step 3 — charges submitted to the plan	$7,340.00	Yes
Plan discount / contractual reduction	$4,151.60	Step 4 — contractual adjustment	$4,151.60	Yes
Allowed amount	$3,188.40	Step 5 — plan allowed amount	$3,188.40	Yes
Applied to deductible	$1,200.00	Step 7 — deductible portion	$1,200.00	Yes
Coinsurance (20%)	$397.68	Step 7 — coinsurance portion	$397.68	Yes
Plan paid	$1,590.72	Step 6 — plan payment received	$1,590.72	Yes
Patient responsibility	$1,597.68	Step 7 — total cost share	$1,597.68	Yes
Not shown on the EOB	—	Step 8 — non-covered self-administered drugs	$72.00	N/A

Seven of the eight rows must match exactly. The eighth cannot appear on the EOB because those charges were never submitted to the plan. If a row other than the last one does not match, stop and call us before paying.

YOUR 2027 PLAN ACCUMULATORS

ACCUMULATOR	PLAN LIMIT	MET TO DATE	REMAINING
Individual deductible	$2,500.00	$2,500.00	$0.00
Individual out-of-pocket maximum	$7,350.00	$3,309.68	$4,040.32

Before this claim, $1,300.00 of the deductible had been met; the $1,200.00 applied in step 7 satisfied the remainder. The out-of-pocket figure is the $2,500.00 deductible plus $397.68 of coinsurance from this claim plus $412.00 of cost share from earlier 2027 claims. The $72.00 of non-covered charges does not count toward either accumulator.

PROFESSIONAL FEES BILLED SEPARATELY

PHYSICIAN GROUP	WHAT THEY BILL FOR	BILLING PHONE
Fairhaven Emergency Physicians, PA	Emergency physician services on 04/18/2027	1-855-555-0141
Cedar Ridge Radiology Associates	Interpretation of the chest radiograph and CT	1-855-555-0143
Valley Pathology Consultants	Laboratory professional component (no charge applied)	1-855-555-0145

These groups bill on their own statements and are not part of the $7,412.00 above. Receiving more than one bill for a single visit is expected; receiving the same charge twice is not.

CHECK THIS STATEMENT LINE BY LINE BEFORE YOU PAY

- ☐ The service date on every line is a day I was actually at the facility.
- ☐ Each test, image, and medication listed is one I remember receiving or can confirm.
- ☐ The observation quantity of 8 hours matches how long I was held for monitoring.
- ☐ No line appears twice with the same code, date, and amount.
- ☐ The troponin line shows 2 units because the test was repeated, not billed twice.
- ☐ Every payment I made appears in step 10 or step 11.
- ☐ The EOB reconciliation table above matches on all seven comparable rows.
- ☐ The deductible and coinsurance amounts match my plan's cost-sharing rules.
- ☐ Charges from the physician groups above are on their statements, not this one.
- ☐ I have asked about financial assistance or a payment plan if I cannot pay in full.

You may request an itemized statement at any time at no cost, and we will provide it within 10 business days. You may also request the medical record documentation behind any line.

WHAT EACH COLUMN MEANS

Rev. code	The four-digit revenue code identifying the department or category that produced the charge.
CPT / HCPCS	The standardized procedure code describing the service. A dash means the line is a room, supply, or pharmacy charge that has no procedure code.
Qty	Units billed — hours of observation, milligrams of a drug, or repetitions of a test.
Unit charge	Our published price for one unit before any insurance contract.
Contractual	The discount our agreement with your plan requires. It is removed permanently and is never your responsibility.
Allowed	The negotiated ceiling for the service. Your cost share is calculated from this number, not from the charge.

WAYS TO RESOLVE THIS BALANCE

1. Pay in full at mvhs.example/billing, by phone at 1-855-555-0130, or by mail using the remittance stub. A 10% prompt-pay courtesy applies if paid in full by July 4, 2027.
2. Set up an interest-free payment plan — see form MVH-PFS-PP-031, *Payment Plan Options*, or call 1-855-555-0130.
3. Apply for financial assistance — see form MVH-FAP-014. Applications are accepted for 240 days after the first post-discharge statement, which is until December 31, 2027.
4. Dispute a specific line by calling 1-855-555-0130 or faxing 1-855-555-0139. The disputed amount is held for 30 days while it is reviewed.
5. Ask for a patient financial advocate at 1-855-555-0136 if you are not sure which of these paths fits your situation.

Please note: This statement reflects how one claim was processed on one account. It is not a coverage determination, a statement of what any other service will cost, financial advice, or a waiver of your right to dispute a charge. Nothing on this page should be used to decide what care to seek or to predict what another patient, plan, or facility would be charged.