ECU PHYSICIANS
Smart medicine

The Brody School of Medicine
Greenville, NC

Patient
Statement Date
Account#
Pay This Amount
Amount Enclosed:

Person that received services
Date bill generated
Number ID for Account
Owed by Patient
Amount you're paying

002256 WECET175
Person Responsible for Bill
Street Address
City, STATE ZIP

VISA MasterCard

See Reverse Side

[ ] Address or Insurance Change: Check here and complete reverse side

Please Make Checks Payable To : ECU Physicians

Mail To:
ECU Billing Services
P.O. Box 602000
Charlotte, NC 28260-2000

00007795790623190000050008O

DETACH AND PLACE TOP PORTION IN RETURN ENVELOPE

Account# : Number ID for Account

Name of Patient : Person that received services

Total Patient Balance : Same as "Pay This Amount" Above

Charges Pending Insurance

Total **Patient Payments** :
Amount paid toward services

Primary Insurance
Only/Main Insurance on File for Patient

Secondary Insurance: 2nd Insurance on file for patient to be filed after MAIN Insurance

Other Insurance: Any Changes Should be Made on BACK of this Form

See upper coupon for important information regarding insurance changes.

Important Messages Regarding Yo::r Account :· Website and Phone Numbers for Any Questions on Account

PLEASE REMIT PAYMENT IN FULL TO ASSURE YOUR ACCOUNT DOES NOT BECOME PAST DUE AND TO AVOID OUTSIDE COLLECTION ACTIVITY. You· MAY VISIT OUR WEBSITE AT.WWW.ECU.EDU/ECUPHYSICIANS TO PAY YOUR BILL ONLINE OR TO SUBMIT A FINANCIAL ASSISTANCE APPLICATION. YOU MAY ALSO ·CALL 252-744-2128 OR 1-866-277-7024 MON-FRI FROM 8AM-5PM WITH QUESTIONS CONCERNING YOUR ACCOUNT.

THIS STATEMENT DOES NOT INCLUDE ANY HOSPITAL OR OUTSIDE LAB. (ECU Bill ONLY. Vidant, Labs, Anesthesia, etc. will all be billed separately.)

Date of Service	Date of Payments & Credits	Description	Charge	Payment & Credits	Patient Balance
Date(s) Services Performed	Date(s) Payments Posted	This field shows the following: a. Payment (could be insurance or patient) b. Brief description of service(s) provided	Amount billed for service(s) provided	Amount of Self-pay or Insurance Payments Already Made to the Account	Amount owed AFTER all payments & Credits have been applied
		Total Patient Payments		$0	
		Total Patient Balance			$0

WECET175 002256 175100212613 1 CI 2ECETA 005815

TO **PAY BY** CREDIT CARD please complete the following: CHECK ONE: ( ) VISA ( ) MASTERCARD

Card Number | Expiration Date | Amount | Signature of Card Holder

IF YOUR ADDRESS HAS CHANGED Please check if this is the ( ) Patient ( ) Responsible Party ( ) Both

New Street Address | City | State | Zip | Telephone

IF YOUR INSURANCE HAS CHANGED

New Insurance Company Name | Address | City | State | Zip

Policyholder | Group# | Policy# | Effective Date

I HEREBY ASSIGN BENEFITS TO ECU PHYSICIANS AND AUTHORIZE THE RELEASE OF NECESSARY MEDICAL INFORMATION TO PROCESS CLAIMS.

Signature of Patient, Parent or Guardian _____

ECU PHYSICIANS PAYMENT POLICY

PATIENT DUE BALANCE

- **YOUR PAYMENT IS DUE UPON RECEIPT OF THIS STATEMENT.** Failure to remit payment in full may result in the placement of any unpaid balance with an outside collection agency. The North Carolina Department of Revenue may be notified to withhold all or portion of your income tax refund toward satisfaction of this debt. If you are unable to remit payment in full, please contact one of our patient representatives immediately at (252)-744-2128 or 866-277-7024. They are available to answer any questions you have regarding your account, assist you in determining eligibility for special programs, or answer any other financial questions.
- **This bill is for ECU Physician provider services only.** This does not include any hospital or outside lab charges.
- Returned check fee is $25.00.
- Please retain for income tax purposes.

MEDICARE/MEDICAID/BLUE CROSS-BLUE SHIELD/STATE HEALTH PLAN/TRICARE

- ECU PHYSICIANS accepts assignment when filing your claims. This means the insurance carrier will send the payment directly to us.
- As participants in these programs, we will credit your account for the difference between the cost of services and ihe amount aiiowed by your insurance carrier.
- You are responsible for payment of the difference between the amount approved and the amount paid by the carrier, as well as any deductibles, spend down, co-payments or non-covered services. These amounts may be estimated and collected at the time of service.

COMMERCIAL INSURANCE

- If you have provided us with your insurance policy information, as a service we will file claims on your behalf . While we will assist in processing your claim, payment for services is ultimately your responsibility. We must look to you for payment in full if no response is received from your carrier within 45 days of filing the claim.

MANAGED CARE PLANS (HMOs, PPOs)

- ECU PHYSICIANS participates in these special programs known as HMO's or PPO's. Please be sure that you are seen by your primary care provider or have an authorization from your primary care provider to see another physician in our practice. You may be responsible for all or part of any services received **without authorization. You will be responsible for any co-payments.**

Si Usted necesita asistencia con sus cuentas de cobro favor de llamar a la oficina de interpretes al telefono **252- 744-3664.**

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