Cheyenne County HOSPITAL

P.O. BOX 547 | ST FRANCIS KS 67756

CER-307

PATIENT STATEMENT

E Please call 1-877-621-4910 or 785-332-2104 to set up a payment plan if unable to pay your account in full. If you are unable to make a payment plan please ask about our Financial Assistance Program.

A Statement Date- used when inquiring or paying
B Due date
C Total amount due
D Address to remit payment
E Billing questions
F Guarantor address

A Statement Number	B Due Date	C Amount Due	Amount Paid
800025021	01/14/2022	$1,889.21	$

A Page 1 of 1

Addressee

F CSQ V XAMMS
KF XFH 894
381 S MKSOLSW
MGBOC YWGOLBM KS 67756

Please make checks payable and remit to:

D **Cheyenne County Hospital**
PO Box 767
Wichita KS 67201

☐ Check if address/insurance changes are on back

Please detach and return top portion with payment.

Statement Number	Guarantor Name	Statement Date	Due Date
800025021	CSQ V XAMMS	12/15/2021	01/14/2022

Date	Service Description	Charges	Payments/ Adjustments	Patient Balance
B	**Date of Service (06/26/20) CSQ V XAMMS** *Encounter #: 5149257 Provider: Licke, Heather MD* C			
	RADIOLOGY D	$601.00		
08/17/2020	Commercial insurance payment E		$0.00	
	Patient Balance			$601.00
	Date of Service (05/23/19) GDP XAMMS *Encounter #: 5040860 Provider: Korman, David S*			
	PHARMACY	$6,131.75		
	TREATMENT ROOM	$309.30		
10/17/2019	Medicare payment		-$4,418.57	
10/17/2019	Contractual Allowance Adjustment F		-$644.10	
10/17/2019	EDI adjustment credit		-$90.17	
	Patient Balance			$1,288.21

A Number of pages to your statement
B Date of Service/Patient's Name
C Encounter number/ providers name
D Service Description
E Payments listed first (Insurance or personal)
F Adjustments
G Total amount Due
H Online payment system
I Message to Patient concerning bill

H

MESSAGES I

Your insurance has paid its portion or denied, and the balance is now patient responsibility. Please remit payment in full within 30 days or contact 877-621-4910 discuss financial assistance options, or if you have questions concerning your bill.

Pay Online: www.cheyennecountyhospital.com

Total Charges: $7,042.05
Insurance Payments/Adjustments: .....-$5,152.84
Patient Payments/Adjustments: $0.00

G **AMOUNT DUE: $1,889.21**

Change of Address

Name (Last, First, Middle Initial)

Address

City | State | ZIP

Telephone

Do We Have Your Insurance Information?

Accurate insurance information helps ensure prompt payments by your insurance company. Please update any information that has changed since your last statement. Thank you!

Primary Insurance Updates

Primary Insured Name

Primary Insurance Name | Effective Date

Primary Insurance Street Address

City | State | ZIP | Telephone

Employer Name | Group Number

Subscriber ID # | Policyholder's Date of Birth

Secondary Insurance Updates

Secondary Insured Name

Secondary Insurance Name | Effective Date

Secondary Insurance Street Address

City | State | ZIP | Telephone

Employer Name | Group Number

Subscriber ID # | Policyholder's Date of Birth

Cheyenne County Hospital

Plain Language Summary of Financial Assistance Policy

The Cheyenne County Hospital Financial Assistance Program (FAP) exists to provide eligible patients fully discounted emergent or medically- necessary hospital care. Patients seeking Financial Assistance must apply for the program, which is summarized below.

- Eligible Services – Emergent and/or medically necessary healthcare services provided by Cheyenne County Hospital.

- Eligible Patients – Patients receiving eligible services, who submit a Financial Assistance Application (including related documentation/information), and who are determined eligible for Financial Assistance by Cheyenne County Hospital because they are either uninsured or underinsured.

Obtaining financial assistance information – To obtain a copy of the Cheyenne County Hospital financial assistance application, financial assistance policy and/or financial assistance plain language do one of the following:

- Please visit our Billing Office at 210 W. 1st Street St. Francis, KS 67756 and if you need help completing the form someone can assist you.
- Request to have a financial assistance application, financial assistance policy and/or financial assistance plain language summary mailed to you free of charge by calling Patient Financial Services at 785-332-2104.
- Please visit https://www.cheyennecountyhospital.com/patients_visitors/financial_assistance.aspx to access a copy of the financial assistance application and financial assistance program and collection policy.

The financial assistance application, financial assistance policy and/or financial assistance plain language summary are all free to you.

Information on financial assistance and the notice posted in medical center and clinic locations will be translated in any language that is the primary language spoken by 1,000, or 5 percent – whichever is fewer – of the residents in the primary and secondary service area.

Determination of Financial Assistance Eligibility

Generally, patients are eligible for financial assistance based on their income level. The patient's household income must be less than 200% of the Federal Poverty Level (See Appendix A) to qualify for free care. See Financial Assistance Program at https://www.cheyennecountyhospital.com/patients_visitors/financial_assistance.aspx.

No person eligible for financial assistance under the FAP will be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance covering such care.