OhioHealth

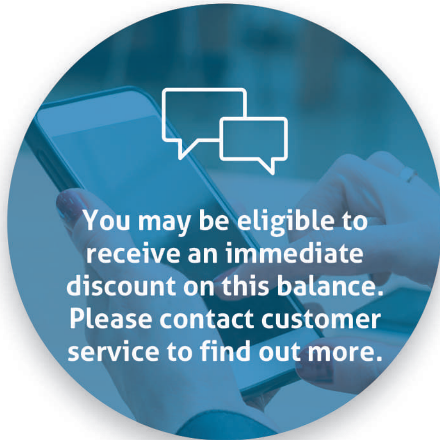
PAST DUE AMOUNT
$1,586.97

RESPONSIBLE PARTY: Sampath Dindu

Account Number
101827134

Statement Date
7/21/2020

We have billed your insurance and the remaining balance is your responsibility. One or more of your accounts is now **PAST DUE**.



YOUR NEXT STEP

Please call to resolve your past due account and discuss payment options or financial assistance.

Financial Assistance

If you are unable to pay, you may be eligible for financial assistance. Financial assistance may be available for patients with family income at or below 400% of the federal poverty guideline. For more information, please visit our website at www.OhioHealth.com, call 614-566-5594 or refer to the back of this statement.

Payment Plan

If you are unable to pay your bill in full, please call 614-566-5594 or 1-800-837-2455. We are open Monday through Friday 7:00AM to 6:00PM.

Pay Online or By Phone Today

Please pay in full online at www.OhioHealth.com, via mail or call 614-566-5594 or 1-800-837-2455.

OhioHealth MyChart

OhioHealth MyChart gives you 24/7 secure online access to your OhioHealth medical information. Go to MyChart.OhioHealth.com and click sign up now to get started.

Transaction summary on next page/page 1 of 2

Detach coupon and return with your payment

OhioHealth PO BOX 1259, DEPT 140155
OAKS PA 19456

☐ Check if address/insurance changes are on the back.

RESPONSIBLE PARTY		
Sampath Dindu		
STATEMENT DATE	ACCOUNT NUMBER	SERVICE DATE
7/21/2020	101827134	5/22/2020
AMOUNT DUE	DUE DATE	SHOW AMOUNT PAID HERE
$1,586.97	8/11/2020	

140149-OH-BAI2L

Pay online at www.OhioHealth.com
Pay by phone calling 614-566-5594 or 1-800-837-2455

Questions, Please Email us at CustomerCenter@OhioHealth.com

PLEASE MAKE CHECKS PAYABLE TO:

SAMPATH DINDU
541 CRIMSONROSE RUN
WESTERVILLE OH 43081-5668

OHIOHEALTH
P.O. BOX 183221
COLUMBUS OH 43218-3221

000101827134000158697 6

OhioHealth

Individuals with income at or below the federal poverty guidelines are eligible for services without charge.
Please see the chart on the right.
To apply, complete the application on the reverse side and fax to 614-566-6080 or mail your application along with income documentation to:

OhioHealth Financial Assistance
P.O. Box 7527
Dublin, OH 43016

Financial assistance is available for those with income at or below 400% of the federal poverty guidelines and meets other qualifications.

2020 Federal Poverty Guidelines	
Size of Family	Yearly Income Level
1	$12,760
2	$17,240
3	$21,720
4	$26,200
Each Additional Person	$4,480

Tips for Completing the Financial Assistance Application

*Please print legibly and use a ball point pen. Do not use gel pens.

*Do not use "N/A" in any field.

* To make corrections, please put a line through the incorrect information, write in the correct information and initial the change.

Field Description	***Details***
Name/Address/Phone Number	Name, address and phone number (including area code) of patient
Account Number	Enter the account number from the front of the statement. If the account number is not available, leave the box blank
Family Members Name	List by name, the family members in the immediate family, including yourself, spouse, children under 18(natural or adoptive) who reside in the home
Age	List the age of each family member next to their name
Relationship	List how this person is related to the patient. Example: Self, Spouse, Child(natural or adoptive), etc.
Source of Income or Employer Name	List the employer's name or any other source of income for this person. This would include unemployment, social security, VA, pensions, etc.
Hire/Start Date for all Income	List the start or hire date at this job, or the date the benefits began, such as with unemployment, social security, retirement, etc.
Income for 3 Months Prior to: Date of Service or Date of Application	Enter amount of gross income each person received 90 days before the service or date of application. If there is no income 90 days prior to service, enter 0
Income for 12 Months Prior to: Date of Service or Date of Application	Enter amount of gross income each person made 12 months before the service or date of application. If there is no income 12 months prior to service, enter 0
If you wrote $0.00 for income, provide an explanation of how you were being supported	Explain your means of support (including the names and phone numbers of the individual(s) supporting you) since there was $0.00 income for 3 months prior to the date of service or date of application. Example: My parents supported me – Mark & Jane Smith 614.111.1111
Value of Assets	List any checking account money, savings, 401K's, 403B's, IRA's, etc. List all property, cars, boats, etc. If there are none, enter 0
Monthly Total Expenses	Total amount of house/rent payment, car payment, utilities, food, etc.
Applicant's Signature	Sign and date the application

NOTE: Make sure the account number is written at the top of all papers sent with application.
Do not staple documents.
Failure to follow these steps or an incomplete application could result in a delay in processing.

OhioHealth

PAST DUE AMOUNT
$1,586.97

Responsible Party	Account Number	Statement Date	Due Date
Sampath Dindu	101827134	7/21/2020	8/11/2020

YOUR TRANSACTION SUMMARY

Log onto MyChart.OhioHealth.com for an itemization of charges

PATIENT	HOSPITAL/ PROVIDER	INSURANCE ON FILE	DATES OF SERVICE	DESCRIPTION	AMOUNT
SAMPATH DINDU					
	Riverside Methodist Hospital	GreatWest	5/22/2020	Radiology	$2,061.00
				Insurance Payments and Adjustments	-$474.03
				Patient Payments and Adjustments	$0.00
				Account Balance	$1,586.97

PAST DUE

This is your second statement and your account is now more than 30 days past due. Please pay the balance due or setup a payment plan immediately by visiting www.OhioHealth.com or calling 614-566-5594 or 1-800-837-2455.

AMOUNT NOW DUE **$1,586.97**

Explanation of your bill

Cost of services		Patient Payments & Adjustments		Insurance Payments & Adjustments		Owed by you
$2,061.00	-	$0.00	-	$474.03	=	$1,586.97

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