MAKE CHECKS PAYABLE TO:

Florence Urgent Care
8820 Bankers Street,
Florence, KY 41042

RETURN ADDRESS REQUESTED
Phone: 859 647-1918

IF PAYING BY MASTERCARD, VISA, DISCOVER OR AMERICAN EXPRESS, FILL OUT BELOW

☐ MasterCard ☐ VISA ☐ DISCOVER

CARD NUMBER	EXP. DATE
SIGNATURE	CVV CODE

INVOICE DATE	PAY THIS AMOUNT	ACCT. #
1/16/2024	**$104.10**	58806

SHOW AMOUNT PAID HERE
$

JAYARAMI REDDY
1315 SCOTTISH LANE
UNION, KY 41091

Florence Urgent Care
8820 Bankers Street,
Florence, KY 41042

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

INVOICE

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	PATIENT	PROVIDER	DESCRIPTION	CHARGES	PAYMENTS & WRITE OFFS	PATIENT BALANCE
11/14/2023	JAYARAMI REDDY	Zineddin	LEVEL 3, EXPANDED; 30 min	$175.00		
			Insurance Adjustment on 11/29/2023		($70.90)	
			final notice deductible			**$104.10**
1/16/2024	JAYARAMI REDDY		Credit		($0.00)	

CURRENT	30 DAYS	60 DAYS	90 DAYS	120 DAYS	150 DAYS	OVER 150 DAYS	PAY THIS AMOUNT
$0.00	**$0.00**	**$104.10**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$104.10**

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

PROMPT PAYMENT IS APPRECIATED

ONLINE PAYMENTS CAN BE MADE USING THE 'EXISTING PATIENT' LINK ON THE 'PATIENT PORTAL' AT HTTPS://FUR.MYEPS3.COM/PP

PLEASE REMIT TO: Florence Urgent Care **ACCOUNT #: 58806** **BILLING QUESTIONS: 859 647-1918**

COMPASS EMERGENCY PHYS
PO BOX 638685
CINCINNATI OH 45263

Pay Online: https://compassemergency.acryness.com

Phone: 513-281-4582

Account Summary

Account Number	5754544
Statement Date	12/21/2023
Patient Name	JAYARAMI PULLAREDDY
Insurance Still Pending	$0.00
Total Patient Responsibility	$60.67

Date	CPT Code	Description	Charges	Payments & Adjustments
11/14/23	99285	EMERGENCY ROOM EXAM	683.00	
12/14/23		ANTHEM PAYMENT COINSURANCE AMOUNT		-242.68
12/14/23		ANTHEM DISALLOWANCE		-379.65
			Amount Due	**$60.67**

Please use the boxes below to update any information that may have changed since your last statement.

ABOUT YOU

YOUR NAME (Last/First Middle initial)	TELEPHONE		
STREET ADDRESS	CITY	STATE	ZIP
EMPLOYER'S NAME	TELEPHONE		
STREET ADDRESS	CITY	STATE	ZIP

MARITAL STATUS
☐ Single ☐ Separated
☐ Married ☐ Divorced

YOUR INSURANCE

PRIMARY INSURANCE COMPANY- SUBSCRIBER NAME	SUBSCRIBER BIRTH DATE		
YOUR PRIMARY INSURANCE COMPANY	ID#	GROUP#	
PRIMARY INSURANCE COMPANY'S ADDRESS	CITY	STATE	ZIP
SECONDARY INSURANCE COMPANY- SUBSCRIBER NAME	SUBSCRIBER BIRTH DATE		
YOUR SECONDARY INSURANCE COMPANY	ID#	GROUP#	
SECONDARY INSURANCE COMPANY'S ADDRESS	CITY	STATE	ZIP

Bill for services provided by **St. Elizabeth Physicians**

Account Number: **800885135**
Total Balance: $79.28
Statement Date: 11/30/23

Scan QR code for Guest Pay

Pay your bill or set up a payment plan
Ask billing questions
View charges, payments and statements
Apply for financial assistance
Generate an estimate for future services
Sign up for paperless billing

Payment Options

- MyChart at **mychart.stelizabeth.com**
- Pay online at **stedocs.com** and select "Pay Bill"
- Mail – Detach bottom portion for payment
- Call Customer Service at **(859) 344-5555** or **(877) 687-3303**

Current Charge Summary

Date	Description	Charges	Credits	Balance
Visit on 11/15/2023 with MILLER, MIRANDA JEAN - Patient PULLAREDDY,JAYARAMI REDDY				
11/15/2023	HOSPITAL DISCHARGE DAY MANAGEMENT	127.00		**79.28**
11/30/2023	Insurance Payment - Anthem		0.00	
11/30/2023	Insurance Adjustment - Anthem		-47.72	
	Total Patient Balance:			**79.28**

PO Box 630839
Cincinnati, OH 45263-0839
Return Service Requested
(859) 344-5555 or Toll Free at (877) 687-3303
Mon-Thurs: 7:30am-5pm   Fri: 7:30am-4pm

O My address and/or insurance information has changed.
I have written the changes on the back of this form.

Statement Date: 11/30/23 **Account Number: 800885135**

MasterCard | AMERICAN EXPRESS | DISCOVER | VISA

CARDHOLDER NAME		
CARD #	EXP	CVV
SIGNATURE		

AMOUNT DUE UPON RECEIPT	AMOUNT ENCLOSED
$79.28	**$**

JAYARAMI REDDY PULLAREDDY
1315 Scottish Lane
Union KY 41091

St. Elizabeth Physicians
PO Box 630839
Cincinnati, OH 45263-0839

Guarantor Number	Statement Date	DUE DATE
1128652	12/3/2023	12/31/2023

$2,996.39

MyChart

Create your own Payment Plan !!!

Our records indicate you have a MyChart account
Go to **http://www.stelizabeth.com/MyChart/**

What can you do in MyChart?

- *Create your own payment plan!*
- Sign up for paperless statements
- View a summary of charges
- Pay your bill
- View payment history
- Ask a billing question

STATEMENT FOR HOSPITAL SERVICES ONLY

Physicians and Other Services are Billed Separately

PAYMENT OPTIONS

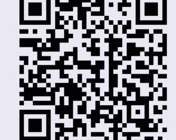
MyChart access
https://mychart.stelizabeth.com/mychart/

Pay Online by visiting www.stelizabeth.com and select "PAY MY BILL"

Mail - Detach bottom portion for payment

You may also call customer service at 877-424-5750, Mon-Fri 8:00am - 4:30pm EDT.

Or scan this QR code with your mobile device



Thank you for choosing St. Elizabeth Healthcare.

158690-STMT-1-3312

CURRENT ACCOUNTS

PATIENT NAME	ACCT NUMBER	DATE	SERVICES	TOTAL CHARGES	INS PAY	INS ADJ	PAT ADJ	PAT PAY	PATIENT BALANCE
OPEN ACCOUNTS (Pay Balance or contact us for payment options, see above)									
Jayarami Reddy Pullar	856617645	11/14/2023	Flo Spine Ctr IP	18,147.22	-8788.64	-6262.19	-15.00	-85.00	**2,996.39**

To see if you may qualify for financial assistance through federal, state or St. Elizabeth's Financial Assistance Program, see reverse side to complete a financial assistance application or go to **www.stelizabeth.com/patients-visitors/financial-assistance-programs**

To ensure proper credit, detach bottom portion and return this portion in the enclosed envelope.

PO BOX 1259 Dept. #158692
Oaks, PA 19456

PLEASE DO NOT REMIT PAYMENT OR SEND ANY CORRESPONDENCE TO THIS ADDRESS

If Paying By Credit Card, Check Box and Please Fill Out Below

☐ VISA ☐ MasterCard ☐ DISCOVER ☐ AMERICAN EXPRESS

Card Number ______________________ Exp. Date __________

Print Name ______________________ Amt. Paid __________

Signature ______________________ CVV Code __________

DUE DATE	AMOUNT DUE	GUARANTOR #
12/31/2023	$2,996.39	1128652

Please call us with insurance and address changes or email us at mybill@stelizabeth.com

ADDRESSEE:

JAYARAMI REDDY PULLAREDDY
1315 SCOTTISH LN
UNION KY 41091-7832

MAKE CHECKS PAYABLE AND REMIT TO:

ST. ELIZABETH HEALTHCARE
PO BOX 630856
CINCINNATI, OH 45263-0856

1000011286523 000299639

***** This is your application for financial assistance, and you must provide applicable proof of income. Income includes: most recent pay stub, tax returns, Unemployment, Worker s Compensation, SSI/SSD, Pension/Retirement, etc. This form may be used for St. Elizabeth Healthcare or Physicians assistance, which are reviewed separately.**

Most Recent Pay-Stub (per adult)	**Tax Return (prior year)**	*** SSI / SSD Recipients**
(Only one pay-stub required that reflects Year-To-Date Gross Income. If not employed as of current year, submit most recent pay stub from employment.)	(Only Page 1 of the most recent Federal Income Tax Return that reflects individuals filing, dependents claimed and adjusted gross income is required.)	Must send SS Award Letter (or Bank Statement showing SS Direct Deposit) * Bank statement must show Bank Name, Patient Name, and deposit.

Patient Name:___________________________________SS # :___________________________Spouse Name ("None" if none):____
Street:____City:____________________________________State and Zip code____

Dependent Name	Age	Dependent Name	Age
1.____________________________	________	4.____________________________	________
2.____________________________	________	5.____________________________	________
3.____________________________	________	6.____________________________	________

Monthly Expenses
Housing.......................................$______________
Automobile..................................$______________
Utilities..$______________
Household Expenses (food, etc.)..$______________
Other(_____________)...............$______________

FAMILY INCOME GROSS (Most Recent 12-Month Period)

	Patient	Spouse	**Question**	**If Yes, Required Documents:**
Income	$_________	$_________	Do you file taxes?	Most recent federal tax return
Social Security	$_________	$_________	Is any adult in the home employed	Most recent pay stub per employed adult
Pension/Retirement	$_________	$_________	Do you receive Social Security?	Annual Award Letter (or Bank Stmt showing deposit)
Disability	$_________	$_________	Do you receive Disability?	Annual Award Letter
Workers Comp	$_________	$_________	Do you receive unemployment?	Benefit Letter
Unemplyment	$_________	$_________	Do you receive retirement/pension income?	Monthly Benefit Letter or Bank Statement
			Do you have any income not mentioned?	Documentation to support
Total	$_________	$_________	Are you claiming $0 income?	Unemployed declaration statement below

Do you have any real estate or financial assets? Yes / No If yes, please explain:____
If you are self employed and do not have pay stubs, please provide prior year taxes and complete the following:
I,__________________am self-employed and have been since_________________. Estimate my gross income at time of application to be:_______________.
If Unemployed, Last Date of Employment:__________________.
If you report $0 income, please provide a brief explanation of how you (the patient) are surviving financially.
____
By my signature below, I certify that everything I have stated on this application attachments is correct.
Patient Signature:_____________________________Spouse Signature:____________________________________Date:________________________

St. Elizabeth Healthcare - FAP Plain Language Summary

Consistent with its mission to provide comprehensive and compassionate care that improves the health of the people we serve, St. Elizabeth Healthcare is committed to providing Financial Assistance to every person in need of medically necessary treatment if that person is uninsured, underinsured, ineligible for other government programs, or unable to pay based on their individual financial situation.

Eligible Services- Services are provided under St. Elizabeth Financial Assistance Policy only when deemed medically necessary and after patients are found to have met all financial criteria based on the disclosure of, and assessment of, proper information and documentation. The St. Elizabeth Financial Assistance Program (FAP) is available for uninsured patients and patients with self-pay balances after insurance. FAP is a charity program based on the patient s family income. Patients with family incomes at or below 200% of the Federal Poverty Guidelines are eligible for 100% charity or free care. Patients with a family income level from 201% to 300% FPG are eligible for a 50% adjustment and individuals with an income level from 301% to 400% FPG are eligible for a 25% adjustment. Patients with family income exceeding 200% of the Federal Poverty Guidelines may also be eligible for the hardship program or catastrophic discount on an individual basis. The Patients expenses and liabilities may be considered in the evaluation of their eligibility for approval. Patients are expected to contribute payment for care based on their individual financial situations; therefore, each case will be reviewed separately. Financial Assistance is not considered an alternative option to payment, and patients may be assisted in finding other means of payment or financial assistance before approval for St. Elizabeth Financial Assistance Program (FAP).

Eligible patients will not be charged more for emergency or other medically necessary care than Amounts Generally Billed (AGB) for those patients who have insurance. Eligible patients are those receiving eligible services, who submit a complete Financial Assistance Application (including related documentation/information), and who are determined to be eligible for Financial Assistance by the St. Elizabeth Healthcare Financial Assistance Department.

How to Receive a Copy of the FAP and Apply for Assistance - Copies of the FAP, FAP application, and a plain language summary of the FAP may be obtained/completed/submitted as follows:

- Complete the application on the reverse side of your billing statement
- Download a copy of the FAP, FAP application, and a plain language summary of the FAP at https://www.stelizabeth.com/resources/pay-my-bill and go to the Resources section
- For questions or to request a copy of the FAP, FAP application, or a plain language summary of the FAP by mail, call the Financial Assistance Department at **877-424-5750**.
- Obtain a copy of the FAP, application, or a plain language summary of the FAP at St. Elizabeth Healthcare, Cashier s Office, 1 Medical Village Drive, Edgewood, KY 41017

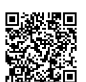
Return completed applications to: St. Elizabeth Healthcare, Attn: Financial Assistance Department, 1 Medical Village Drive, Edgewood, KY 41017 or fax to 859-655-3537 or email to financialassistance@stelizabeth.com. Other services which are separately billed by other providers who are not employees of St. Elizabeth Healthcare, such as independent physicians, are not eligible under the St. Elizabeth Healthcare FAP. For a full listing of these providers, please visit our website at: https://www.stelizabeth.com/resources/pay-my-bill and go to the Resources section. The FAP application and this plain language summary available in English and Spanish.

St. Elizabeth Physician Services

Bill for services provided by **St. Elizabeth Physicians**

Account Number: **1128652**
Total Balance: **$17.27**
Statement Date: **12/03/23**

Scan QR code for Guest Pay



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- Sign up for paperless billing

Payment Options

- MyChart at **mychart.stelizabeth.com**
- Pay online at **stedocs.com** and select "Pay Bill"
- Mail – Detach bottom portion for payment
- Call Customer Service at **(859) 344-5555** or **(877) 687-3303**

Current Charge Summary

Date	Description	Charges	Credits	Balance
Visit on 11/15/2023 with KRASIK, ELLEN F - Patient PULLAREDDY,JAYARAMI REDDY				
11/15/2023	PATHOLOGY EXAM OF TISSUE USING A MICROSCOPE, MODERATELY LOW	26.00		**17.27**
11/30/2023	Insurance Payment - Anthem		0.00	
11/30/2023	Insurance Adjustment - Anthem		-8.73	
	Total Patient Balance:			**17.27**

St. Elizabeth Physician Services

PO Box 630839
Cincinnati, OH 45263-0839

Return Service Requested
(859) 344-5555 or Toll Free at (877) 687-3303
Mon-Thurs: 7:30am-5pm Fri: 7:30am-4pm

O My address and/or insurance information has changed. I have written the changes on the back of this form.

Statement Date: 12/03/23 **Account Number: 1128652**

MasterCard AMERICAN EXPRESS DISCOVER VISA

CARDHOLDER NAME		
CARD #	EXP	CVV
SIGNATURE		

AMOUNT DUE UPON RECEIPT	AMOUNT ENCLOSED
$17.27	**$**

JAYARAMI REDDY PULLAREDDY
1315 Scottish Lane
Union KY 41091

St. Elizabeth Physicians Services
PO Box 630839
Cincinnati, OH 45263-0839