**Sample Billing Statement**

Below is a sample PSA Billing Statement.

**Front of Billing Statement**

Move your mouse over each number for an explanation of that item.

|  |  |  |  |
| --- | --- | --- | --- |
| **Your Pathology or Laboratory Service Provider** http://www.psabilling.com/images/1.gif | **Patient Name** | | |
| http://www.psabilling.com/images/2.gifJANE DOE | | |
|  | **Account #** |  | **Statement Date** |
|  | http://www.psabilling.com/images/3.gif CHR - 0000000-00 |  | http://www.psabilling.com/images/4.gif1/5/2018 |
| Please contact our billing agent, PSA, to submit payment, update information, or speak with a billing representative. | **Due Date** |  | **Amount Due** |
| http://www.psabilling.com/images/5.gif1/15/2018 |  | http://www.psabilling.com/images/6.gif 52.08 |
| |  | | --- | | **IMPORTANT MESSAGE** | | **FIRST NOTICE, PLEASE REMIT PROMPTLY.** The amount shown is your responsibility, please pay by due date. Thank You. http://www.psabilling.com/images/7.gif | | |  |  | | --- | --- | | http://www.psabilling.com/images/8.gif http://www.psabilling.com/images/icon_web.gif | www.psabilling.com | | email: psrbilling@mckesson.com | |  | *Servicio en español, por favor llame.* | | http://www.psabilling.com/images/9.gif http://www.psabilling.com/images/icon_phone.gif | **TOLL FREE: 1-877-268-1012** | | **TOLL FREE FAX: 1-877-268-1254** | | | |
| |  |  |  | | --- | --- | --- | | http://www.psabilling.com/images/10.gif **Our records indicate the following insurance:**           Primary Ins: ABC Health Insurance          Secondary Ins: XYZ Health Insurance | http://www.psabilling.com/images/11.gif **Referring Physician**           JOHN SMITH MD | http://www.psabilling.com/images/12.gif **Office hours:**          Mon-Thur 8am-9pm ET          Fri 8am-8pm |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | DATE | PROC. CODE | DESCRIPTION | QUANTITY | AMOUNT | | http://www.psabilling.com/images/13.gif | http://www.psabilling.com/images/14.gif | http://www.psabilling.com/images/15.gif | http://www.psabilling.com/images/16.gif | http://www.psabilling.com/images/17.gif |  |  |  | | --- | --- | | [http://www.psabilling.com/images/icon_arrow.gif](http://www.psabilling.com/SampleBillingStatement.aspx#Back) | These charges are not included in any other hospital, laboratory or physician statement. For more information or to update insurance information, see the back of this statement or visit www.psabilling.com. |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | |  | | --- | | **BILLING OFFICE ADDRESS:** |   http://www.psabilling.com/images/18.gif | |  |  |  | | --- | --- | --- | | STATEMENT DATE 1/5/2018 | **DUE DATE  1/15/2018** | ACCOUNT # CHR-0000000-00 |   http://www.psabilling.com/images/19.gif Check # \_\_\_\_\_\_\_\_\_ (Please do not staple) | **AMOUNT DUE $52.08** | | ABC PATHOLOGY PO BOX 1070 CHARLOTTE NC 28201 | |  | | --- | | **AMOUNT  ENCLOSED $** | | | | http://www.psabilling.com/images/21.gif | http://www.psabilling.com/images/20.gif http://www.psabilling.com/images/credit_cards_grey.gif | | | Patient Name: JANE DOE http://www.psabilling.com/images/icon_box.gifPlease check box if address or insurance information is incorrect and indicate change(s) on reverse side. | **Do Not Mail Credit Card Information.** **To pay by Credit Card**, visit us at: www.psabilling.com or call: 1-877-268-1012 | | | **ADDRESSEE:** | **MAKE CHECKS PAYABLE TO & REMIT TO:** | | | http://www.psabilling.com/images/barcode.gif | http://www.psabilling.com/images/barcode.gif | | | http://www.psabilling.com/images/22.gif  JANE Q DOE 128 TALBERT RD STE J MOORESVILLE NC 28117-9123 | http://www.psabilling.com/images/23.gif  YOUR PATHOLOGY OR LABORATORY SERVICE PROVIDER PO BOX 1070 CHARLOTTE NC 28201-1070 | | | | | |
| 0000 00000000 000000000000000 0 00000000 00000000 0 | | | |

**Back of Billing Statement**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **PAYMENT METHODS** Please mail all payments with the bottom portion of this statement and return to the address shown on the reverse side. We accept personal checks, money orders, cashier’s checks and major credit cards for the payment of balances due. If you are unable to pay your bill in full or on time, please contact us to discuss payment arrangements. A service charge may be applied on returned checks.  **REQUEST FOR TEST RESULTS** As a billing agent, we are not legally permitted to discuss test results.   **WHY DID I RECEIVE THIS BILL?** This statement is for services rendered for diagnostic testing and results requested by your doctor which were performed at the physician’s office and/or hospital. These charges are not included in any other hospital, laboratory or physician statement. PSA will file your insurance with the information supplied from the requesting facility and you will receive a statement for the amount you are required to pay after insurance has paid its portion of the bill or denied payment. By providing the most current insurance information, you can help expedite this process.   Please submit new or updated insurance information below, for the date that services were provided. If your address or phone number has changed since your last statement, please indicate below.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Your Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | PRIMARY INSURANCE | Insured Name | Insured Birth Date | Effective Date | Employer Name | | Group Number or Plan Number | | Policy ID Number | Relationship Self         Child Spouse   Other | | Insurance Name | Insurance Address | | City      State      Zip | | SECONDARY INSURANCE | Insured Name | Insured Birth Date | Effective Date | Employer Name | | Group Number or Plan Number | | Policy ID Number | Relationship Self         Child Spouse   Other | | Insurance Name | Insurance Address | | City      State      Zip | | MEDICARE | Medicare Part B Number | | | | | MEDICAID | Medicaid Number | | | For State: | |