RETURN SERVICE REQUESTED

☐ Please check box if below address is incorrect or insurance information has changed and indicate changes on reverse side.

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REMIT TO:

NEW YORK UNIVERSITY
PHYSICIAN SERVICES
P.O. BOX 415662
BOSTON, MA 02241

STATEMENT DATE	PATIENT NAME	ACCOUNT #	TOTAL BALANCE	PAY THIS AMOUNT	AMOUNT PAID
11/02/16	) , 5 6 7 / $ 6 7	; ; ; ;	$129.46	$129.46	$

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT.

STATEMENT SUMMARY

AMOUNT BILLED	YOUR INSURANCE PLAN PAID	DISCOUNTS APPLIED	YOUR PATIENT RESPONSIBILITY	YOU ALREADY PAID	YOUR TOTAL BALANCE	AMOUNT DUE
$420.00	$0.00	$290.54	$129.46	$0.00	$129.46	$129.46

To pay by credit card or contact customer service please call: (877) 648-2964 or visit http://mychart.nyulmc.org .

STATEMENT DETAILS

Service Date	Provider	Description	Charges	Credits	Insurance Balance	Patient Balance
RADIOLOGY						