



P.O. BOX 77026 | MINNEAPOLIS MN 55480-7726

CLINIC STATEMENT

For Billing Questions: Local: (651) 265-1999, Toll Free: 1-877-655-2669, TTY: 1-800-627-3529, Office Hours - M,T,W,F: 8am - 5pm, Th: 9am - 5pm

Check if payment, address/insurance changes are on back

Addressee

SAMPLE PATIENT, 1234 MAIN ST, ALBERT LEA, USA 56007-5432

Quick Pay Now Available! Fast, easy, and better for the environment. Pay online today! No login required. https://www.healthpartners.com/quickpay

Table with 4 columns: INVOICE NUMBER (A), ACCOUNT NUMBER (B), DUE DATE (C), AMOUNT DUE (D); BALANCE FORWARD (E), PAYMENTS SINCE LAST STATEMENT (F), NEW CHARGES (G), AMOUNT PAID (H)

Please make checks payable and remit to:

HEALTHPARTNERS, PO BOX 77026, MINNEAPOLIS, MN 55480-7726

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You may pay your bill online at https://www.healthpartners.com/quickpay.

Please detach and return top portion with payment.

Summary table with columns: Account Number (I), Account Name (J), Statement Date (K), Due Date (L)

Main statement table with columns: Date (M), Service Description (N), Charges (O), Payments/Adjustments (Insurance (P), Patient (Q)), Patient Balance (R)



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MESSAGES

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AMOUNT DUE:

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- A. Invoice Number: A number that identifies this statement. B. Account Number: A number that identifies your account. C. Due Date: If you are on a Payment Plan, the date you agreed to when you set-up your Payment Plan will appear here. D. Amount Due: Total account balance. E. Balance Forward: Unpaid balance that was billed on a previous statement. F. Payments Since Last Statement: \*Any payments you have made since last statement. G. New Charges: Charges that have never appeared on prior statements. H. Amount Paid: This field will always be blank.

\*Payments received and applied towards outstanding balance on/after statement date may not appear on current month's statement.

You will also find more helpful information on the back of your statement.

- I. Account Number: A number that identifies your account. J. Account Name: Your name. K. Statement Date: Date statement was printed and mailed. L. Due Date: Date payment should be received. M. Date: Date the service was received. N. Service Description: The name of the patient who received the service, and the location where services were received. O. Charges: The billed charges for the service described in box N. P. Insurance Payments/Adjustments: Any payments or adjustments from insurance for the services described in box N. Q. Patient payments/Adjustment's: Any payments made by you. R. Patient Balance: The amount you owe for the service described in box N. S. Messages: Important messages regarding your account. T. Amount Due: Total account balance or monthly Payment Plan amount (if you are on a Payment Plan).