



Stony Brook
Medicine

BOBBY KANT WOLSKI
13843 OWL TREE ST
MEDFORD OR 97501

Important Message

This Bill Is For Services Rendered By Univ. Hosp. You May Receive An Additional Bill For Phys Svc. To Pay With A Major Credit Card Or Give Add'L Ins Info Plse Complete The Reverse Side Of This Bill & Return It In The Envelope Provided. If You Need Financial Assistance, Call 444-4331 Or Visit Our Website At Stonybrookmedicine.edu/Billinginformation

Account Summary

Patient Name: **Bobby Kant Wolski**
Statement Date: **12/20/13**
Service Date(s): **12/01/13-12/01/13**
Account Number: **29566331**
Medical Record Number: **853968932157**

Insurance Information

INS 1: INSURANCE 1
INS 2: INSURANCE 2
INS 3:
INS 4:

Charge Summary

Total Charges:	\$1,985.40
Payments/Adjustments:	\$1,939.79
Account Balance:	\$50.00
 Please Pay This Amt:	 \$50.00

Contact Us

For questions, call customer service at:
631-444-4151

Make Checks Payable To: STONY BROOK UNIV HOSPITAL



 **Stony Brook Medicine**
PO BOX 1546 ~ STONY BROOK NY 11790
ADDRESS SERVICE REQUESTED

Check box if your address or insurance information has changed. Please make changes on back.

00000001 001 0.53
BOBBY KANT WOLSKI
13843 OWL TREE ST
MEDFORD OR 97501

Account Number: 29566331	Please Pay This Amount: \$50.00		
Patient Name: Bobby Kant Wolski	Due By: 01/12/14		
<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>	
Card Number:	CVV2 No.*	Exp. Date:	
Signature:	Amount Paid:		

* The CVV2 Number is the last 3 digits on the back of your credit card, by your signature.

STONY BROOK UNIV HOSPITAL
P.O. BOX 29320
NEW YORK, NY
10087-9320



**Stony Brook
Medicine**

Account Summary

Patient Name: **Bobby Kant Wolski**
Statement Date: **12/20/13**
Service Date(s): **12/01/13-12/01/13**
Account Number: **29566331**
Medical Record Number: **853968932157**
Please Pay This Amt: **\$50.00**

Charge Information

<u>Trans. Date</u>	<u>Description</u>	<u>Charges</u>	<u>Est Ins Coverage</u>	<u>Payments/Adj's</u>
12/01/13	ED VISIT LEVEL 3	99283	1117.00	1117.00-
12/01/13	FOREARM/RT	73090RT	269.00	269.00-
12/01/13	WRIST/RT	73110RT	269.00	269.00-
12/01/13	ELBOW, RT 3VIEW	73080RT	322.00	322.00-
12/01/13	OXYCOD/APAP TAB	J8499	8.40	8.40-
12/09/13	B.C. ALW OP (SYS)			1118.40
12/20/13	BLUE CROSS PMT IP/OP			821.39
12/20/13	COPAY AMT.			.00
				1118.40- 821.39- .00

Please use this space to make corrections to your address or insurance information.

Name: _____ Account No: _____ Phone: _____

Address: _____

Business Phone: _____ Employer: _____

Employer Address: _____

Insurance Company: _____ Effective Date: _____

Insurance Company Address: _____ Phone: _____

Insurance Policy or Contact No: _____ Group No: _____

Policy Holder's Name: _____ Phone: _____

Policy Holder's Date of Birth: _____ Policy Holder's Gender: M F Policy Holder's Social Security No: _____

Patient's Relationship to Insured: Self Spouse Child Other _____