Sutter Medical Center of Santa Rosa

P.O. BOX 1828
Novato Ca 94948

Return Service Requested

[redacted]

[redacted]

Account Summary	
Date of Bill:	5/12/2011
Date of Service:	04-29-11
Account number:	
Total Charges:	$1,324.00
Adjustments:	$0.00
Uninsured Discount:	($476.64)
Patient Payments:	$0.00
What You Owe Now:	$847.36
Due Date:	6/6/2011
If your prompt payment is received by 06-27-2011 what you owe is:	$762.62

Please see reverse side for patient billing details ⇨

Dear [redacted]

Thank you for choosing Sutter Medical Center of Santa Rosa for your health care needs. This bill includes the hospital services you received, and is your responsibility. Our records show that you have no health insurance coverage for this account so we have applied our UNINSURED DISCOUNT. Please contact our Customer Service Team if you have any questions or submit full payment by the due date.

Sincerely,
Patient Accounts

Questions
Please contact us at 800-326-6674

Mon-Tues 8am-6pm, Wed-Fri. 8am-5pm

Insurance Information
We currently do not have any insurance information on file for your account. If this is not correct, please contact us at your earliest opportunity or send in your information with the form on the reverse side of this page.

See reverse side to update your insurance information ⇨

Please detach and send with your payment.
Please remember to put your account number on your check.

Date of Service: 04-29-11
Patient Name:
WID:

Guarantor Name	Account number	Due Date
		6/6/2011
Amount Due	**Amount I am Paying**	
$847.36		

☐ VISA ☐ MasterCard ☐ Discover ☐ AMERICAN EXPRESS

REMIT THIS PAYMENT TO:

Sutter Medical Center
of Santa Rosa
P.O. BOX 60000, File No. 73684
San Francisco, CA 94160

Name as it appears on the card

Card No. _____

Expiration Date _____ CCV Code _____

Signature x _____

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