

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