

252 Brodhead Road
Suite 400
Bethlehem, PA 18017
For services not included in your
physician's bill.

Customer Service

- **Call:** 1-866-621-5234; **Fax:** 570-214-5741
- **Hours:** Weekdays 8AM to 6PM; Saturday 9AM-1PM
Se habla Espanaol 8AM - 6PM Tiempo del Este
- **Email:** provenbillingsupport@provendiagnostics.com
Please remember that information sent to us via email is not secure. If you must communicate sensitive health or financial information, please call the number above.

Invoice Number 1234567890

LABORATORY TESTS WERE REQUESTED BY:

Referring Physician: SMITH, JOHN
Physician Address: 1234 MAIN ST.
ANYTOWN, USA 99999-9999

INSURANCE ON FILE FOR INVOICE:

Insurance Name	Insurance ID	Group Number
INSURANCE CO. 1	1234567	123456
INSURANCE CO. 2	2345678	456789

LAB RESULTS AND DIAGNOSIS QUESTIONS MUST BE ANSWERED BY YOUR PHYSICIAN.

Patient Name:	John Q. Patient	Invoice Date:	8/01/2009
Responsible Party:	John Q. Patient	Amount Due:	\$47.00
Date of Service:	7/25/2009	Payment Due Date:	8/30/2009

We have received a payment from your insurance company. According to our records, there is a remaining balance. Please pay the remaining balance and provide your invoice number on your check. Thank you for using Proven Diagnostics.

DATE	CPT CODE*	TEST DESCRIPTIONS	CHARGE	INSURANCE DISCOUNT	INSURANCE PAID	MEDICARE/MEDICAID PAID	PATIENT PAID	PATIENT OWES
7/25/09	82465	CHOLESTEROL	\$20.00					
7/25/09	83718	HDL	47.00					
7/25/09	84478	TRIGLYCERIDES	20.00					
7/25/09	36415	VENIPUNCTURE	10.00					
7/31/09		PAYMENT RECEIVED			50.00			
			\$97.00	\$0.00	\$50.00	\$0.00	\$0.00	\$47.00

Tax ID: 23-2077663 ICD-9 Codes: 788, 43, 272, 2
Services Performed By: Proven Diagnostics, Bethlehem, PA

* The CPT codes provided are based on AMA guidelines and without regard to specific payor requirements.

TO INSURE PROPER CREDIT, DETACH AND RETURN BOTTOM PORTION IN THE ENCLOSED ENVELOPE.

PAYMENT COUPON

PROVENSM
DIAGNOSTICS
252 Brodhead Road
Suite 400
Bethlehem, PA 18017

34567



0101

PATIENT NAME: JOHN Q. PATIENT

Please check if address below is incorrect and indicate change on reverse side.

IF PAYING BY MASTERCARD, VISA, DISCOVER OR AMERICAN EXPRESS, FILL OUT BELOW.		
CHECK CARD USING FOR PAYMENT		
<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> AMERICAN EXPRESS
<input type="checkbox"/> VISA		
CARD NUMBER	SIGNATURE CODE	
SIGNATURE		EXP. DATE
INVOICE DATE	AMOUNT DUE	INVOICE NUMBER
8/01/2009	\$47.00	1234567890
IF YOU RECEIVED AN EXPLANATION OF BENEFITS SHOWING YOUR RESPONSIBILITY IS LESS THAN THE AMOUNT SHOWN ON THIS BILL, PLEASE PAY THE LESSER AMOUNT. TO FULLY RESOLVE YOUR INVOICE, PLEASE PROVIDE A COPY OF YOUR EXPLANATION OF BENEFITS.		
DUE DATE	SHOW AMOUNT PAID HERE \$	
8/30/2009		

Make Check Payable to Proven Diagnostics.

600000 (4/09)

JOHN Q PATIENT
123 MAIN STREET
ANYTOWN, USA 12345-6789

PROVEN DIAGNOSTICS
LOCKBOX #9276
PO BOX 8500
PHILADELPHIA, PA 19178-9276



Billing Policy

We will file your claim with your insurance company. Please complete all patient and policy holder information below and return in the envelope provided. We will submit benefit claims to your insurance company if all required information is provided.

We participate with many insurance companies. If you have a specific question about your coverage, please contact your insurance company representative. You are responsible for all deductibles, coinsurance, copays, and any items not paid by your insurance.

Patient Information	Patient's Name		Invoice #	Patient's Phone #	
	Patient's Social Security #		Patient's Date of Birth		Gender <input type="checkbox"/> M <input type="checkbox"/> F
Medicare* Medicaid Information	Medicare ID #: (include all letter and numeric characters)			Please verify if Medicare is your primary insurance <input type="checkbox"/> YES <input type="checkbox"/> NO	
	Medicaid ID#: (include all letter and numeric characters)				
Insurance Information	Insurance Company or Health Plan Name			Please verify if this insurance plan is your primary insurance <input type="checkbox"/> YES <input type="checkbox"/> NO	
	IPA or Medical Group Name (if applicable)			Insurance Phone #	
	INSURANCE ID # (Include all letter and numeric characters)		GROUP # (Include all letter and numeric characters)		Patient's Relationship to the Policyholder <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT
	Claims Address		City	State	Zip
	Policyholder Name		Policyholder's Employer		

* If you have Medicare, Railroad Medicare or Medicaid as your primary or secondary insurance coverage, please document this information in the spaces provided.

ADDRESS CORRECTION OR CHANGE OF ADDRESS INFORMATION REQUESTED (Please Print)

Responsible Person's Name		Home Phone # ()	Work Phone # ()	
Address		City	State	Zip

