Beaumont | HEALTH SYSTEM

Business Center
750 Stephenson Highway
PO Box 5042
Troy, MI 48007-5042

To pay your bill online or contact us:
www.beaumont.edu/bill-pay
or
248.577.9600
Monday-Friday 8:00am-6:30pm

Patient Number	4868899
Patient Name	CHUBANYUK, DENIS YURI
Statement Date	09-10-12
Guarantor Number	1947822
Statement Balance	$124080.62

4868899
ELENA CHUBANYUK
42843 POTOMAC DRIVE
NOVI, MI 48375

Coverages on file:

Federal Tax ID
38-1459362

Date	Diagnosis Codes	Description	Remark Codes	Charges	Payments/ Adjustments	Insurance Balance	Patient Balance
07/03/12-07/26/12 Visit# 48688992010							
ROYAL OAK HOSPITAL							
Hospital Charges							
		ANESTHESIA GENERAL		10654.00			
		BLOOD STORAGE AND PROCESSING GENERAL		2047.00			
		COMPUTED TOMOGRAPHIC (CT) SCANS - GEN		5093.00			
		DRUGS REQUIRING SPECIFIC IDENTIFICATI		14943.34			
		INTENSIVE CARE GENERAL		75762.00			
		LABORATORY - GENERAL		27873.98			
		MEDICAL/SURGICAL SUPPLIES AND DEVICES		67488.40			
		OCCUPATIONAL THERAPY GENERAL		2463.00			
		OPERATING ROOM SERVICES - GENERAL		29422.00			
		OTHER IMAGING SERVICES GENERAL		84.00			
		PHARMACY GENERAL		11899.65			
		PHYSICAL THERAPY GENERAL		1519.00			
		PULMONARY FUNCTION GENERAL		3848.00			
		RADIOLOGY DIAGNOSTIC		4109.00			
		RESPIRATORY SERVICES GENERAL		20327.00			
		PATIENT PAYMENT (08-16-12)			-42590.60		
08-21-12		UNINSURED DISCOUNT			-111013.35		
		Totals		277533.37	-153603.95	0.00	123929.42
Professional/Physician Charges							
		SKULL < 4 VWS		79.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CT, MAXILLOFACIAL AREA, W/O CONTRAST		274.00			
		3D INDEPENDENT WORKSTATION (PRO)		235.00			

Hospital Balance:	$123929.42
Professional/Physician Balance:	$151.20

Please retain statement for your records. See reverse side for bill explanation.

DETACH AT PERFORATION AND RETURN THIS PORTION WITH YOUR PAYMENT

5000 080411 OS8

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To Ensure Proper Credit
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Guarantor Number: 1947822
Statement Date: 09-10-12
Guarantor Name: ELENA CHUBANYUK
Statement Number: 316372961

Due Date:	
You Owe:	
Amount Paid:	

000019478221 003163729613 12392942 00015120 12408062 7

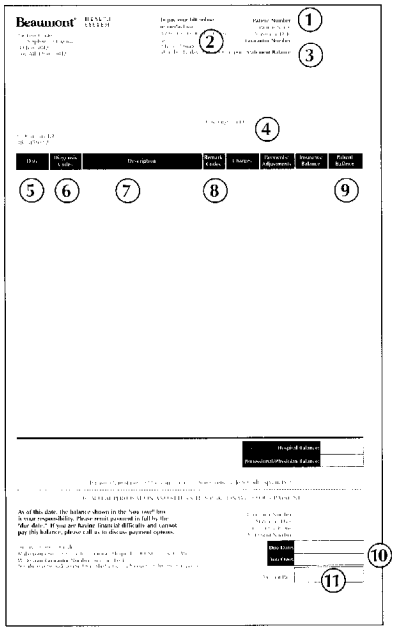
AN EXPLANATION OF YOUR BILL:

At Beaumont, we will submit your bill to all known sources of insurance coverage. If you incur any non-covered services, (like television or telephone services, or your insurance notifies us of any co-pays or annual deductibles) you will be billed immediately. As sources pay their share, we will send you a bill for any additional amounts due. When multiple physicians are involved in your case, you will most likely receive more than one bill. This is because most insurance companies handle hospital and physician payments separately.

Since it takes a considerable amount of time for some insurance companies to finalize claims, your final bill may be delayed a long time from the date your service was rendered. Please do not disregard our billings. Also please keep all documentation your insurance company sends you. This will help you understand the portion we are required to bill you.

Thank you for utilizing Beaumont for your medical care. We will make every attempt to minimize the inconvenience of the billing process. If you have any questions or problems with your bill, please contact or write us to resolve the issue.

UNDERSTANDING YOUR BILL:



1 Your Patient Number is also your patient identification number. Please refer to it when you have questions about your bill.

2 This section offers you specific information about whom to call if you have questions regarding this bill.

3 The Statement Balance is the total amount you owe at the time of this billing.

4 This area identifies the name(s) of your insurance company(s).

5 This is the date(s) your medical care was provided.

6 This is the primary medical diagnosis code.

7 This is a description of services that were provided. If both hospital and physician services were utilized, there will be two sections showing the charge associated with the hospital or physician services provided.

8 Refer to Remark Codes description for details.

9 This is the amount you owe for each service, your policy co-pay or annual deductible.

10 This is the total amount You Owe at the time of this billing.

11 Please use this area to identify the amount of your payment.

REMARKS CODE DESCRIPTION:

A Based on your benefits, your insurance company applied these charges towards your deductible/co-pay or member liability. The balance reflected is now your responsibility.

B Your insurance carrier has rejected these charges. Your contract has been terminated. If you have any questions regarding this claim, please contact your insurance carrier. This balance is now your responsibility.

C Your insurance carrier has rejected these charges. They are unable to identify the patient and/or subscriber. This balance is now your responsibility.

D In order for us to bill your automobile carrier for these services, we must have the claim number, billing address and the medical benefit information on file. Please contact our office with this information as soon as possible. Until this information is received this balance remains your responsibility.

E Your insurance carrier has rejected these charges because the maximum annual benefit for this service has been met. Please contact your insurance carrier if you have any questions regarding this rejection.

F Your insurance carrier has been billed for services. However, the listed personal items are a non-covered benefit. At this time, the balance reflected is your responsibility.

G As of today, your billing still remains outstanding. We have not received payment from your insurance carrier. Their failure to comply regretfully forces us to bill you. This billing is now your responsibility.

H Your insurance carrier has determined that your illness is not a reimbursable medical emergency and they have rejected payment. This balance is now your responsibility.

I Your insurance company has rejected this claim due to service not authorized. Please contact your primary care physician or insurance carrier directly if you should have any questions. This balance is now your responsibility.

J Your workers compensation carrier has rejected these charges as not work related. This balance is now your responsibility.

K Your insurance carrier states your other insurance is primary. Please contact our office with the appropriate insurance information and we will resubmit this bill to your insurance carrier or please remit the balance due.

L Your insurance carrier has denied these services. They have determined that this is a pre-existing condition. This is now your responsibility.

M The balance reflected as your responsibility is your spend down amount established by Medicaid. This amount is your responsibility.

N Your insurance carrier has denied payment on this claim due to the lack of coordination of benefits letter. Please complete this letter and return to your insurance company as soon as possible. At this time, the balance remains your responsibility.

O Your insurance carrier has denied payment for these services as not a covered benefit. This amount is now your responsibility.

P Portion of this charge is patient's responsibility for a private room.

5000 080811 OSB

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If you are paying your bill with your Visa, MasterCard, Discover or American Express please call 248-577-9600, or complete the following information and mail in the envelope provided.

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Expiration date: _____ Cardholder's Signature _____

Month/Year

Card Number

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Patient Number	4868899
Patient Name	CHUBANYUK, DENIS YURI
Statement Date	09-10-12
Guarantor Number	1947822
Statement Balance	$124080.62

4868899
ELENA CHUBANYUK
42843 POTOMAC DRIVE
NOVI, MI 48375

Coverages on file:

Federal Tax ID
38-1459362

Date	Diagnosis Codes	Description	Remark Codes	Charges	Payments/ Adjustments	Insurance Balance	Patient Balance
	755.55	INSERT CVAD < AGE 5YRS, PICC LINE SER		551.00			
		US GUIDE FOR VASC ACCESS SITES		168.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CT NECK W/CONTRAST		335.00			
		CT HEAD W & W/O CONTRAST		713.00			
		CT MAXIFACIAL W/CONTRAST		312.00			
		3D INDEPENDENT WORKSTATION (PRO)		235.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
	755.55	IP PED CRIT CARE-INITIAL-PER DAY 29D		1237.00			
	755.55	IP PED CRIT CARE-SUB-PER DAY 29D TO 2		630.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
	755.55	IP PED CRIT CARE-SUB-PER DAY 29D TO 2		630.00			
	755.55	IP PED CRIT CARE-SUB-PER DAY 29D TO 2		630.00			
	755.55	IP PED CRIT CARE-SUB-PER DAY 29D TO 2		630.00			
	755.55	IP PED CRIT CARE-SUB-PER DAY 29D TO 2		630.00			
	755.55	IP PED CRIT CARE-SUB-PER DAY 29D TO 2		630.00			
	755.55	IP PED CRIT CARE-SUB-PER DAY 29D TO 2		630.00			
	755.55	IP PED CRIT CARE-SUB-PER DAY 29D TO 2		630.00			
	755.55	IP PED CRIT CARE-SUB-PER DAY 29D TO 2		630.00			
		CHEST SINGLE VW		55.00			
		CHEST SINGLE VW		55.00			
		CT, MAXILLOFACIAL AREA, W/O CONTRAST		274.00			
		MOD BAR SWALLOW W/VIDEO		139.00			
		3D INDEPENDENT WORKSTATION (PRO)		235.00			
	518.81	SUBSEQ CRIT CARE PEDS 2Y - 5Y, PICU -		630.00			
	518.81	SUBSEQ CRIT CARE PEDS 2Y - 5Y, PICU -		630.00			
	518.81	SUBSEQ CRIT CARE PEDS 2Y - 5Y, PICU -		630.00			
	518.81	SUBSEQ CRIT CARE PEDS 2Y - 5Y, PICU -		630.00			
	518.81	SUBSEQ CRIT CARE PEDS 2Y - 5Y, PICU -		630.00			
	518.81	SUBSEQ CRIT CARE PEDS 2Y - 5Y, PICU -		630.00			
	518.81	SUBSEQ CRIT CARE PEDS 2Y - 5Y, PICU -		630.00			
		GASTROSTOMY, OPEN, W/TUBE CNSTR		1565.00			
	518.52	TRACHEOSTOMY, PLANNED, PEDIATRIC SURG		1509.00			

Hospital Balance:	$123929.42
Professional/Physician Balance:	$151.20

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Guarantor Number:	1947822
Statement Date:	09-10-12
Guarantor Name:	ELENA CHUBANYUK
Statement Number:	316372961
Due Date:	
You Owe:	
Amount Paid:	

000019478221 003163729613 12392942 00015120 12408062 7

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Patient Number	4868899
Patient Name	CHUBANYUK, DENIS YURI
Statement Date	09-10-12
Guarantor Number	1947822
Statement Balance	$124080.62

4868899
ELENA CHUBANYUK
42843 POTOMAC DRIVE
NOVI, MI 48375

Coverages on file:

Federal Tax ID
38-1459362

Date	Diagnosis Codes	Description	Remark Codes	Charges	Payments/ Adjustments	Insurance Balance	Patient Balance
	755.55	TRACHEOTOMY TUBE CHANGE BY PHYSICIAN,		175.00			
	755.55	INITIAL INPAT CONSULT,MOD COMPLEX, PE		279.00			
	755.55	SUBSQNT HOSP CARE PER DAY DETAILED, P		76.00			
	755.55	SUBSQNT HOSP CARE PER DAY DETAILED, P		76.00			
		RECONST FACE,LEFORT III COMPLEX		4222.00			
		MAXILLOFACIAL FIXATION		703.00			
		EXTEN CRANIEC W RECONTOUR SYNOSTOSIS		4260.00			
	755.55	ADJUST EXTERN BONE FIX DEV W ANESTH,		733.00			
		ANESTH,SKIN SURG HEAD/NECK		520.00			
		ANESTH,SKIN SURG HEAD/NECK		585.00			
	755.55	SUBSEQUENT HOSP CARE PER DAY COMP, PI		114.00			
	755.55	SUBSEQUENT HOSP CARE PER DAY COMP, PI		114.00			
	755.55	SUBSEQUENT HOSP CARE PER DAY COMP, PI		114.00			
	755.55	SUBSEQUENT HOSP CARE PER DAY COMP, PI		114.00			
	755.55	SUBSQNT HOSP CARE PER DAY DETAILED, P		76.00			
	518.81	SUBSQNT HOSP CARE PER DAY HIGH MDM, P		142.00			
	518.81	SUBSQNT HOSP CARE PER DAY HIGH MDM, P		142.00			
07-03-12		UNINSURED DISCOUNT			-31.60		
07-04-12		UNINSURED DISCOUNT			-22.00		
07-04-12		UNINSURED DISCOUNT			-22.00		
07-05-12		UNINSURED DISCOUNT			-22.00		
07-06-12		UNINSURED DISCOUNT			-22.00		
07-06-12		UNINSURED DISCOUNT			-22.00		
07-06-12		UNINSURED DISCOUNT			-22.00		
07-06-12		UNINSURED DISCOUNT			-22.00		
07-07-12		UNINSURED DISCOUNT			-22.00		
07-08-12		UNINSURED DISCOUNT			-22.00		
07-09-12		UNINSURED DISCOUNT			-22.00		
07-09-12		UNINSURED DISCOUNT			-109.60		
07-09-12		UNINSURED DISCOUNT			-94.00		
07-10-12		UNINSURED DISCOUNT			-220.40		
07-10-12		UNINSURED DISCOUNT			-67.20		
07-10-12		UNINSURED DISCOUNT			-22.00		
07-11-12		UNINSURED DISCOUNT			-22.00		
07-11-12		UNINSURED DISCOUNT			-22.00		
07-12-12		UNINSURED DISCOUNT			-22.00		
07-13-12		UNINSURED DISCOUNT			-134.00		
07-13-12		UNINSURED DISCOUNT			-285.20		
07-13-12		UNINSURED DISCOUNT			-124.80		

Hospital Balance:	$123929.42
Professional/Physician Balance:	$151.20

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5000 0804TI CS8

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Guarantor Number: 1947822
Statement Date: 09-10-12
Guarantor Name: ELENA CHUBANYUK
Statement Number: 316372961

Due Date:	
You Owe:	
Amount Paid:	

000019478221 003163729613 12392942 00015120 12408062 7

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Patient Number	4868899
Patient Name	CHUBANYUK, DENIS YURI
Statement Date	09-10-12
Guarantor Number	1947822
Statement Balance	$124080.62

4868899
ELENA CHUBANYUK
42843 POTOMAC DRIVE
NOVI, MI 48375

Coverages on file:

Federal Tax ID
38-1459362

Date	Diagnosis Codes	Description	Remark Codes	Charges	Payments/ Adjustments	Insurance Balance	Patient Balance
07-13-12		UNINSURED DISCOUNT			-94.00		
07-13-12		UNINSURED DISCOUNT			-22.00		
07-14-12		UNINSURED DISCOUNT			-22.00		
07-15-12		UNINSURED DISCOUNT			-22.00		
07-16-12		UNINSURED DISCOUNT			-494.80		
07-16-12		UNINSURED DISCOUNT			-252.00		
07-16-12		UNINSURED DISCOUNT			-22.00		
07-17-12		UNINSURED DISCOUNT			-22.00		
07-18-12		UNINSURED DISCOUNT			-252.00		
07-18-12		UNINSURED DISCOUNT			-252.00		
07-18-12		UNINSURED DISCOUNT			-252.00		
07-18-12		UNINSURED DISCOUNT			-252.00		
07-18-12		UNINSURED DISCOUNT			-252.00		
07-18-12		UNINSURED DISCOUNT			-252.00		
07-18-12		UNINSURED DISCOUNT			-252.00		
07-18-12		UNINSURED DISCOUNT			-252.00		
07-18-12		UNINSURED DISCOUNT			-22.00		
07-19-12		UNINSURED DISCOUNT			-22.00		
07-21-12		UNINSURED DISCOUNT			-109.60		
07-23-12		UNINSURED DISCOUNT			-55.60		
07-23-12		UNINSURED DISCOUNT			-94.00		
07-26-12		UNINSURED DISCOUNT			-252.00		
07-26-12		UNINSURED DISCOUNT			-252.00		
07-26-12		UNINSURED DISCOUNT			-252.00		
07-26-12		UNINSURED DISCOUNT			-252.00		
07-26-12		UNINSURED DISCOUNT			-252.00		
07-26-12		UNINSURED DISCOUNT			-252.00		
07-26-12		UNINSURED DISCOUNT			-252.00		
07-26-12		UNINSURED DISCOUNT			-626.00		
07-26-12		UNINSURED DISCOUNT			-603.60		
07-26-12		UNINSURED DISCOUNT			-70.00		
07-30-12		UNINSURED DISCOUNT			-1688.80		
07-30-12		UNINSURED DISCOUNT			-281.20		
07-30-12		UNINSURED DISCOUNT			-1704.00		
07-30-12		UNINSURED DISCOUNT			-293.20		
07-31-12		UNINSURED DISCOUNT			-45.60		
07-31-12		UNINSURED DISCOUNT			-45.60		
07-31-12		UNINSURED DISCOUNT			-45.60		
07-31-12		UNINSURED DISCOUNT			-45.60		

Hospital Balance:	$123929.42
Professional/Physician Balance:	$151.20

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Coverages on file:

Federal Tax ID
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Date	Diagnosis Codes	Description	Remark Codes	Charges	Payments/ Adjustments	Insurance Balance	Patient Balance
07-31-12		UNINSURED DISCOUNT			-30.40		
		PATIENT PAYMENT (08-01-12)			-19368.60		
08-16-12		UNINSURED DISCOUNT			-56.80		
08-16-12		UNINSURED DISCOUNT			-56.80		
		PATIENT PAYMENT (08-16-12)			-170.40		
		Totals		31541.00	-31541.00	0.00	0.00
08/23/12		**Visit# 48688992013**					
ROYAL OAK CLINICAL SERVICES CLINIC LOCATION							
Professional/Physician Charges							
	755.55	E&M, NEW, COMPREHENSIVE HIGH, PEDIATR		252.00			
08-27-12		UNINSURED DISCOUNT			-100.80		
		Totals		252.00	-100.80	0.00	151.20

Hospital Balance:	$123929.42
Professional/Physician Balance:	$151.20

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Guarantor Number: 1947822
Statement Date: 09-10-12
Guarantor Name: ELENA CHUBANYUK
Statement Number: 316372961

Due Date:	10-07-12
You Owe:	$124080.62
Amount Paid:	

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