universityhealth

7900 LEES SUMMIT RD | KANSAS CITY MO 64139

PATIENT STATEMENT

For help with billing questions, please call:
816-404-3040
Office Hours: 8:00AM-4:30PM Mon-Fri
☐ Check if address/insurance changes on back

IF PAYING BY CREDIT CARD, FILL OUT BELOW

CHECK CARD USING FOR PAYMENT ☐ MasterCard ☐ DISCOVER ☐ VISA

CARD NUMBER | EXP. DATE M M Y Y

SIGNATURE

Pay Online: www.trumed.org/patients-visitors/paybill

Statement Number	Due Date	Amount Due	Amount Paid
	04/25/2022	$0.00	$

Addressee

Please make checks payable and remit to:

TRUMAN MEDICAL CENTER LAKEWOOD
P.O. BOX 957986
ST. LOUIS, MO 63195-7986

3475660000000011445210000000000202204110

Please detach and return top portion with payment.

Statement Number	Guarantor Name	Statement Date	Due Date
		04/11/2022	04/25/2022

Date	Service Description	Charges	Payments/ Adjustments	Patient Balance
	Date of Service (04/05/22) *Loc: UH LAKEWOOD MEDICAL CENTER*			
04/05/2022	PHARMACY	$37.10		
04/05/2022	IV THERAPY	$73.00		
04/05/2022	EMERG ROOM	$945.00		
04/05/2022	DRUGS/DETAIL CODE	$5.05		
04/05/2022	EKG/ECG	$129.00		
	VISIT TOTAL			**$0.00**

MESSAGE

A claim has been submitted to Medicare. If you have any additional insurance information, please call our office or mail it in using the back of this letter. Thank you for choosing Truman Medical Center for your healthcare needs.

Pay Online: www.trumed.org/patients-visitors/paybill

Total Charges: $1,189.15
Insurance Payments/Adjustments:.....$0.00
Patient Payments/Adjustments: $0.00

AMOUNT DUE: $0.00