IF PAYING BY VISA, MASTERCARD, AMERICAN EXPRESS OR DISCOVER, FILL OUT BELOW
☐ VISA   ☐ MASTERCARD   ☐ AMER EXP   ☐ DISCOVER
CARD NUMBER   AMOUNT
SIGNATURE   EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.

1

CHARGES AND CREDITS MADE AFTER STATEMENT
DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT
PAID HERE $

UAHSF
DEPARTMENT 2050
PO BOX 2153
BIRMINGHAM, AL 35287-2050

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH
YOUR PAYMENT IN ENCLOSED ENVELOPE

2 Date	Provider	Invoice No.	Description	Transactions
1/1/2019	Dr. Blaze	XXX	Medical Services **3**	$ 100 **4**
			Insurance Payment **6**	– $ 75 **6**
			Contract Adjustment **5**	– $ 10 **5**
			Patient Payment	– $ 10
			Subtotal	$ 5

Customer Service at 205-731-9050
Toll Free at 1-877-533-0334

Please make checks payable to: **UAHSF**

Patient Balance: $ 5 **7**

University of Alabama Health Services
Foundation, P.C.
P.O. Box 55309
Birmingham, Alabama 35255-5309
Tax ID# 63-0649108

To pay online, go to: https://uabhealth.ixt.com

Statement Date:
Patient Name:
Account Number

STATEMENT
SEE REVERSE SIDE FOR IMPORTANT BILLING INFORMATION

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1) Account Information
Brief summary of the statement date, amount due, and account number

2) Date of Service
Date when the medical services were provided

3) Description of the Services
Codes and brief description of the services that were charged

4) Charge
The cost of the services that were charged

5) Adjustment
Adjustments to the charges based on contractual agreements between the healthcare facility and your insurance company

6) Insurance Payment
How much your insurance paid for the services charged

7) Patient Balance
The amount you owe for the services, when the charges, adjustments, insurance payments, and any prior payments you made are taken into account