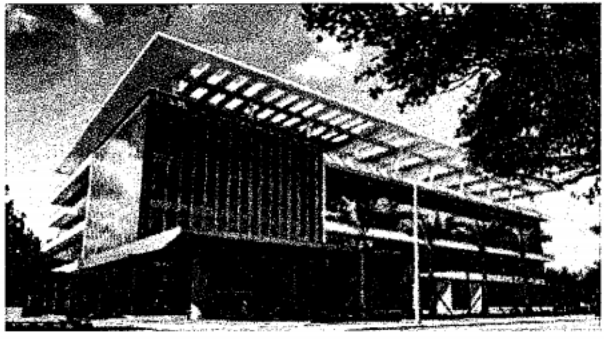




Statement Date: 02/19/21  
MRN: [REDACTED]  
Guarantor ID: [REDACTED]



**Thank you for choosing UHealth for your health care needs.**

Our records indicate the balance on this statement is your responsibility.

Para asistencia en Espanol, por favor llame al 305-243-2900 de Lunes a Viernes 8:30 a.m.-5:00 p.m.

**Responsible Party:**  
MENDOZA,JOSE E

**Active Insurance:**  
HUMANA



**Pay Online**  
[MyUHealthChart.com](http://MyUHealthChart.com)  
You can ask billing questions, enroll in paperless statements, and request copies of your records all online.



**Pay by Phone**  
Call 305-243-2900  
8:30 a.m.-5:00 p.m. Monday through Friday



**Pay by Mail**  
Complete the form below and return in the enclosed envelope.

**Account Summary**

Previous Statement Amount	\$55.00
New Services	\$9,853.00
Other Visit Activity	\$0.00
Insurance Paid/Adj	\$-4,696.15
You Paid	\$-55.00

---

**Account Balance** **\$5,156.85**

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**Current Amount Due** **\$5,156.85**  
**Due by Date** **3/12/2021**




*Detach and return stub. Please make checks payable to University of Miami Health System.*

*Pay online at [www.MyUHealthChart.com](http://www.MyUHealthChart.com)*





Please Complete the Appropriate Sections and Return in the Enclosed Envelope as Soon as Possible


Card Type           Credit Card Number

Amt \$ \_\_\_\_\_ Cardholder Signature \_\_\_\_\_ Exp Dt 

M	M	Y	Y
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To update online, enroll in [MyUHealthChart.com](http://MyUHealthChart.com)

**Change of Address**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_  
 Guarantor Account: 

**Change of Insurance Information**

Will this  replace or  supplement existing coverage?  
 Policy Holder \_\_\_\_\_ DOB \_\_\_\_\_  
**Insurance**  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
**Policy Information**  
 Effective Date \_\_\_\_\_  
 Policy Number \_\_\_\_\_  
 Group Number \_\_\_\_\_

### UHealth Financial Assistance

We are here to serve you. The details in this statement may help you compare this information to information you have received from your insurance company, or if you want to follow up on an unpaid balance. Please contact your insurer for inquiries related to your insurance cost-sharing responsibilities.

UHealth will send you a monthly statement when you have an outstanding balance. We do this, so you have current information about your account. Should you need more information or have questions, refer to "Contact Us" on page one of this statement, or call **305-243-2900** or toll-free **1-800-563-1055**.

The University of Miami Health System provides financial assistance for medically necessary services provided to patients who are in the U.S. legally with family income levels up to four times the Federal Poverty Income Guidelines, as shown below. Financial assistance applies to both hospital and physician services in Florida. We offer payment plan arrangements to assist you in meeting your financial obligations. Please visit **MyUHealthBill.com** for more information or call customer service at **305-243-2900** or toll-free **1-800-563-1055**.

Effective January 1, 2020

Size of Family Unit	Federal Poverty Income Level 2020	UHealth Financial Assistance Income Guidelines**
1	\$12,880.00	\$51,520.00
2	\$17,420.00	\$69,680.00
3	\$21,960.00	\$87,840.00
4	\$26,500.00	\$106,000.00
5	\$31,040.00	\$124,160.00
6	\$35,580.00	\$142,320.00
7	\$40,120.00	\$160,480.00
8	\$44,660.00	\$178,640.00
For each additional person, add	\$4,540.00	

\*\*Family income level up to four times Federal Poverty Income Level (assistance provided on a sliding scale based on income level).

If you believe you may qualify or wish to receive more information regarding the financial assistance program at UHealth, please contact the Customer Service Department at **305-243-2900**. To file a complaint with the Agency for Health Care Administration, please call toll free **1-888-419-3456**.

Si usted cree que califica, o desea recibir mas información sobre el programa de asistencia financiera de UHealth, por favor comuníquese con el Departamento de Servicios Financieros para el Paciente al **305-243-2900**. Para presentar una reclamación a la Agencia de Administracion de Atencion medica, llame al **1-888-419-3456**.

### MyChart- Your Interactive Health Record

MyUHealthchart is a secure, online health management tool that connects you to personalized health information including, test results, upcoming and past appointments, and your list of medications. You can also ask billing questions and request copies of your records. It is completely confidential. To sign up, please ask your physician or log onto **MyUHealthChart.com**.

Visit to AB FL 5 SLEEP  
 Visit ID: [REDACTED]  
 Patient Name: MENDOZA, JOSE E  
 Hospital Charges  
 Balance Due

Date	Description	Charges	Pmts/Adjs	Patie Balan
02/05/2021	Other Diagnostic Services	\$9,853.00		
	HUMANA Payments		-\$262.30	
	Deductible: \$4,894.54			
	Coinsurance: \$262.31			
	HUMANA Adjustments		-\$4,433.85	
	<b>Your Responsibility</b>			<b>\$5,156.00</b>



Name: Jose E Mendoza | [REDACTED] PCP: Ricardo Luis Perez, MD

## Customer Service Regarding Billing

All pieces of information are required to request customer service.

Expect a response within 2 business days. **Monday thru Friday (except holidays and weekends)**

**From: Jose E Mendoza**

Account Number

[REDACTED]

Regarding:

Billing or Account Issue

Message:

This is my third attempt to obtain an itemized billing for the summary bills with statement date 02/19/21 for the amount of \$5,156.85. My prior to request were verbally by phone with customer service at 305 243 2900. The first was on 03/29/21 and today was the second request. The first I was offered a copy of the summarized bill and today I was instructed to retrieve it from this site. However, this is again only the summarized under "Other Diagnostic Services". I want to see the CPT codes used for billing the the details of everything is being charge. You can reach my wife at [REDACTED] if you have any question.

# SmartEOB

Your personal Explanation  
of Benefits summary

THIS IS NOT A BILL

Jose Mendoza

**Birth Year:** [REDACTED]  
**Group name:** Ric Man International  
Inc  
**Group ID:** [REDACTED]  
**Medical plan:** HML  
**Medical ID:** [REDACTED]  
**Medical network:** HMO PREMIER  
**Dental ID:** [REDACTED]  
**Dental network:** HS195 DHMO/PREPAID  
NETWORK

We strongly encourage all Humana members to consider getting the COVID-19 vaccine when they are eligible, and as medically appropriate. Talk to your doctor about what is best for you. Eligibility may vary, so check with your state or local health department on rules in your area. Visit us at [Humana.com/coronavirus](https://www.humana.com/coronavirus) for the latest.

**Humana.**

HUMANA MEDICAL PLAN, INC.  
P.O. BOX 14601  
LEXINGTON, KY 40512-4601

Claims summary period  
February 14, 2021 - February 26, 2021

## Your medical and prescription expenses

▼ <b>Total billed charges</b>	<b>\$10,329.31</b>
Plan discounts/exclusions	-\$4,797.39
Benefit exclusions	-\$0.00
Allowed amount	\$5,531.92
Amount plan pays	-\$262.30
▶ Medical costs	\$262.30
▶ Prescription costs	\$0.00
<b>Your total share</b>	<b>\$5,269.62</b>
▶ Medical costs	\$5,262.31
▶ Prescription costs	\$7.31

## Your dental expenses

▼ <b>Total billed charges</b>	<b>\$0.00</b>
Plan discounts/exclusions	-\$0.00
Benefit exclusions	-\$0.00
Allowed amount	\$0.00
Amount plan pays	-\$0.00
<b>Your total share</b>	<b>\$0.00</b>



**Plan discounts:** Amount you saved because of Humana's negotiated rate with providers.

**Plan exclusions:** Amounts the plan does not allow and that you are not responsible for. Please refer to the reason codes in your statement for more details.

**Allowed amount:** The amount the plan covers for the service.

**Benefit exclusions:** Specific conditions or services listed in your Benefit Plan Document that your plan does not provide benefits for. Please refer to the reason codes in your statement for more details.

**Your share:** This is the amount you owe or may have paid to your providers.

Your personal Explanation of Benefits summary

**Medical claims** February 14, 2021 - February 26, 2021

This section lists new medical claims that were processed this period or previously processed claims that were adjusted this period. If you believe a claim was processed incorrectly, you will need to submit a written grievance and appeal. If you suspect fraud, please contact Humana Inc., 1100 Employers Blvd., Green Bay, WI 54344 (1-800-614-4126). The legal entity for your medical coverage is Humana Medical Plan, Inc. This material is provided for informational use only and should not be construed as medical or other professional advice or used in place of consulting a licensed professional. You should consult with an applicable licensed professional to determine what is right for you.

- Coinsurance:** A percentage of health care costs that you are responsible for paying. For example, you might pay 20 percent of the cost of a service, and your plan might pay the remaining 80 percent.
- Copay:** A fixed amount of health care costs for which you are responsible.
- Deductible:** The portion of your health care expenses that must be paid out of pocket before your plan begins paying its share.

**Medical claims**

<p><b>Claim #</b> [REDACTED] <b>Processed on 2/14/21</b></p> <p>Patient account # [REDACTED]</p> <p>UNIVERSITY OF MIAMI HOSPITAL AND CL 2/5/21-2/5/21</p> <p>Laboratory Services (0920), <b>In-Network</b></p> <p><b>Reason code:</b> 45/6H0</p>	<p>Total charge \$9,853.00</p> <p>Plan discounts/exclusions -\$4,433.85</p> <p>Benefit exclusions -\$0.00</p> <p>Allowed amount \$5,419.15</p> <p>Amount plan pays -\$262.30</p> <p>Copay \$0.00</p> <p>Deductible \$4,894.54</p> <p>Coinsurance \$262.31</p> <hr/> <p><b>Your share \$5,156.85</b></p>
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► **Plan payment has been issued to your provider.**

<p><b>Claim #</b> [REDACTED] <b>Processed on 2/14/21</b></p> <p>Patient account # [REDACTED]</p> <p>UMDC DIVISION OF PULMONARY CRITICAL 2/5/21-2/5/21</p> <p>Diagnostic Radiology (95811), <b>In-Network</b></p> <p><b>Reason code:</b> 45/6H0</p>	<p>Total charge \$469.00</p> <p>Plan discounts/exclusions -\$363.54</p> <p>Benefit exclusions -\$0.00</p> <p>Allowed amount \$105.46</p> <p>Amount plan pays -\$0.00</p> <p>Copay \$0.00</p> <p>Deductible \$105.46</p> <p>Coinsurance \$0.00</p> <hr/> <p><b>Your share \$105.46</b></p>
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<b>Claims summary total:</b>	<b>Your total share \$5,262.31</b>
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Medical claims continued on next page →






Your personal Explanation of Benefits summary



 Are you experiencing Cold, Flu, or Strep Throat systems? With Doctor On Demand®, physicians are here to support your well-being virtually. Doctor On Demand can be your first contact when you have a healthcare need. Download the Doctor on Demand app and register today.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

 You can see a doctor anytime, anywhere! Get treated virtually for non-emergency conditions to avoid a costly trip to the emergency room or urgent care when your PCP isn't available. Virtual visits treat a range of conditions such as cold and flu, sinus infections, rashes and more. You can consult with a U.S. based and board certified doctor by video or phone 24/7/365 for \$56 or less, depending on your plan. Prescriptions may be sent to your pharmacy of choice. Get started now by visiting [www.doctorondemand.com/humana](http://www.doctorondemand.com/humana) or download the Doctor On Demand app. No appointment necessary!

Virtual visits are not a substitute for emergency care and not intended to replace your primary care provider or other providers in your network. This material is provided for informational use only and should not be construed as medical advice or used in place of consulting a licensed medical professional.

**Reason code descriptions for medical claims**

45/6H0 This provider is a member of the Humana Network. Services are discounted according to the negotiated rate.



Your personal Explanation of Benefits summary

**Rx** Prescription claims February 14, 2021 - February 26, 2021

This list shows all of your submitted prescription claims and total costs your plan covered for this period. Adjusted claims may not be reflected in this list or may show an amount that is different than what was listed prior to the adjustment. The cost of the prescription displayed is the average retail price at the pharmacy at the time of purchase and does not take into account other reimbursements. Retail prices on prescription drugs can vary by pharmacy, quantity, strength and/or dosage of the drug.

Prescription claims				
<b>1/28/21 PUBLIX PHARMACY #1247 Claim # [REDACTED]</b> <b>In-network</b> losartan-hydrochlorothiazide 0/50-12.5 MG,1	Prescription cost		\$6.06	
	Amount plan pays		-\$0.00	
	Copay		\$6.06	
	Deductible		\$0.00	
	Coinsurance		\$0.00	
	<b>Your share</b>			<b>\$6.06</b>
	<hr/>			
<b>1/28/21 PUBLIX PHARMACY #1247 Claim # [REDACTED]</b> <b>In-network</b> gabapentin 0/100 MG,1	Prescription cost		\$1.25	
	Amount plan pays		-\$0.00	
	Copay		\$1.25	
	Deductible		\$0.00	
	Coinsurance		\$0.00	
	<b>Your share</b>			<b>\$1.25</b>
	<hr/>			
<b>Claims summary total:</b>		<b>Your total share</b>	<b>\$7.31</b>	

- Rx** The prescription and over-the-counter medicines you use may dry out your mouth. Saliva fights bacteria in the mouth and a lack of saliva may put you at risk for cavities. When taking medicines, make sure you drink plenty of water, avoid sucking on hard candies and/or cough drops, and practice good oral hygiene. Also, let your dentist know about any medicines you take or if you switch medicines.
- Rx** Make sure you take notes about how to take your medicine. It's important to take your medicine the way your doctor tells you. You may need to take certain medicines with food, or take them in the morning. Make sure you follow your doctor's orders.



## Plan year-to-date summary | January 1, 2021 to February 26, 2021

### Your medical and prescription expenses

<b>▼ Total billed charges</b>	<b>\$10,329.31</b>
Plan discounts/exclusions	-\$4,797.39
Benefit exclusions	-\$0.00
<b>Allowed amount</b>	<b>\$5,531.92</b>
<b>Amount plan pays</b>	<b>-\$262.30</b>
▶ Medical costs	\$262.30
▶ Prescription costs	\$0.00
<b>Your share</b>	<b>\$5,269.62</b>
▶ Medical costs	\$5,262.31
▶ Prescription costs	\$7.31





### Your dental expenses

<b>▼ Total billed charges</b>	<b>\$0.00</b>
Plan discounts/exclusions	-\$0.00
Benefit exclusions	-\$0.00
<b>Allowed amount</b>	<b>\$0.00</b>
<b>Amount plan pays</b>	<b>-\$0.00</b>
<b>Your share</b>	<b>\$0.00</b>

Need help and don't want to call? Just Ask Humana. Ask Humana is an online search tool that answers frequently asked questions 24 hours a day. Just type your question in the search bar at the top of [Humana.com](https://www.humana.com) or MyHumana to get your answer.

## Deductibles and maximum out-of-pocket

What you paid out-of-pocket for medical, prescription, and dental claims this plan year.

Medical Deductible			
Individual In-network Deductible (Jan 1, 2021 to Feb 26, 2021)	\$0.00		\$5,000.00 You have paid \$5,000.00. The deductible has been met.
Family In-network Deductible (Jan 1, 2021 to Feb 26, 2021)	\$0.00		\$10,000.00 You have paid \$5,000.00. \$5,000.00 remaining
Medical Maximum Out-of-Pocket			
Individual In-network Out-of-pocket Maximum (Jan 1, 2021 to Feb 26, 2021)	\$0.00		\$6,500.00 You have paid \$5,269.62. \$1,230.38 remaining
Family In-network Out-of-pocket Maximum (Jan 1, 2021 to Feb 26, 2021)	\$0.00		\$13,000.00 You have paid \$5,269.62. \$7,730.38 remaining




Use in-network providers to avoid extra out-of-pocket costs and maximize your benefits. Out-of-network providers may cost you more. Out-of-network providers include: doctors, care professionals, facilities (such as hospitals, lab or surgery centers), or specialists. Ask your doctor or healthcare facility if they are in-network before having a screening or procedure. You can also use the Humana's "Find a doctor" tool at the bottom of the [Humana.com](https://www.humana.com) page.



Your personal Explanation of Benefits summary

Secondary plan benefits

This section lists your secondary benefits. These benefits start over at the beginning of each plan year. Some plan benefits have limitations and rules about how they are applied. Please read the Limitations and Exclusions section of your Benefit Plan Document for more information. You can find your Benefit Plan Document on MyHumana at Humana.com by going to the Coverage and Benefits page and clicking the Coverage Details link.

 Annual limit	 Amount used	 Amount remaining
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<span style="font-size: 0.8em;">▼</span> Medical			
Home Health Care Visit Limit (Jan,1 2021 to Feb 26, 2021)	100	000	100
Nutritional Counseling Visit Limit (Jan,1 2021 to Feb 26, 2021)	004	000	004
Physical Therapy Visit Limit (Jan,1 2021 to Feb 26, 2021)	015	000	015
Skilled Nursing Facility Visit Limit (Jan,1 2021 to Feb 26, 2021)	060	000	060
Speech Therapy Visit Limit (Jan,1 2021 to Feb 26, 2021)	015	000	015
Physical/Occupational/Cognitive/Speech/ Audiology Chiropractic Therapy Visit Limit (Jan,1 2021 to Feb 26, 2021)	060	000	060

Your privacy is important to us

At Humana, your personal, health and financial information is confidential. Humana protects your information and only uses or discloses your information in accordance with federal and state privacy laws and Humana's privacy policy. For additional information on Humana's privacy policy, please access Humana's Notice of Privacy Practices on the Web at [Humana.com/legal/privacy](https://www.humana.com/legal/privacy).



## Claim Information

If you have questions about your claims, we want to help you find answers. Follow these steps when you need information:

Contact us at **1-800-4Humana** or visit us at **Humana.com**.

If your claim was denied due to missing information or requests for additional information, you or your provider may resubmit the claim with the complete information.<sup>1</sup>

If you are covered by more than one benefit plan, file all claims with each plan.

**You may request more explanation when your claim is denied or the cost of the service you received was not fully covered. Contact us when you:**

- Do not understand the reason for the denial;
- Do not understand why the cost was not fully covered;
- Cannot find the applicable provision in your Benefit Plan Document, Policy, or Certificate;
- Want a copy (free of charge) of the guideline, criteria, or clinical rationale that we used to make our decision; or
- You can also request diagnosis and treatment codes and descriptions.

## Appeal Rights

If you disagree with the denial or the amount not covered and want to appeal follow these steps:

**Appeals:** All appeals for claim denial (or any decision that does not cover expenses you believe should have been covered) must be sent to Grievance and Appeals, P.O. Box 14546, Lexington KY 40512-4546 within **180 days** of the date that you receive the denial.<sup>2</sup> We will provide a full and fair review of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claim. We will notify you of our decision in writing within **60 days** of receiving your appeal.<sup>3</sup>

**External Review:** You may have the right to pursue an independent medical review that may be available in your state. For details, please review your Benefit Plan Document, Policy, or Certificate or contact us at the phone number above.

**Consumer Assistance:** For members of a group health plan, questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.askebsa.dol.gov](http://www.askebsa.dol.gov).

**Court Review:** If your plan is governed by ERISA and you want a court to review our final decision, you may file a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA). Be sure you have exhausted your ERISA appeal rights.

<sup>1</sup>See address and phone number on the enclosed Explanation of Benefits.

<sup>2</sup>Unless your plan or any applicable state law allows you additional time.

<sup>3</sup>Some states and plans allow more (or less) time for our decision. See your Benefit Plan Document for any state specific appeal timeframes and process.



## Important!

### At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:  
Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618  
If you need help filing a grievance, call **1-877-320-1235** or if you use a TTY, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

### Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

### Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。

**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

**Tagalog (Tagalog - Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.

**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

**日本語 (Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

**فارسی (Farsi)**

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

**Diné Bizaad (Navajo):** Wóda'í béésh bee hani'í bee wolta'ígíí bich'í' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'déé nika'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220

UHEALTH  
University of Miami Health Systems  
P.O. Box 402005  
Atlanta, GA 30384-2005  
Ph:



Guarantor Name & Address  
MENDOZA, JOSE E



Detailed Bill For

Patient Name: MENDOZA, JOSE E  
Account Class: Outpatient Admission Date: 02/05/21  
Attending Physician: Chediak, Alejandro D., Discharge Date: 02/05/21  
Location: MD  
ABLEH PARENT

Hospital Charges

Service Date	Cost Ctr.	Rev. Code	Proc. Code	Description	Qty.	Amount
02/05/21	1088	0920	501700690	HCHG POLYSOMNOGRAPHY W/ CPAP	1	9,853.00

Total Charges: 9,853.00

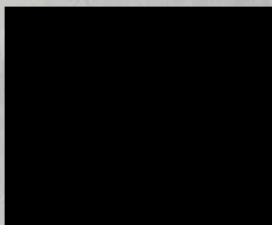
Hospital Payments and Adjustments

Date	Description	Amount
02/19/21	HUMANA Payments	-262.30
	Deductible: 4,894.54	
	Coinsurance: 262.31	
02/10/21	HUMANA Adjustments	-4,433.85

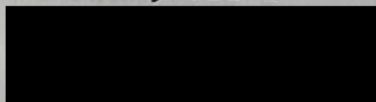
Total Payments: -262.30  
Total Adjustments: -4,433.85

Total Balance: 5,156.85

UHEALTH  
University of Miami Health Systems  
P.O. Box 402005  
Atlanta, GA 30384-2005  
Ph:



Guarantor Name & Address  
MENDOZA, JOSE E



Detailed Bill For

Patient Name: MENDOZA, JOSE E  
Account Class: Outpatient  
Attending Physician: Admission Date: 02/05/21  
Location: ABLEH PARENT Discharge Date: 02/05/21

Professional Charges

Service Date	Bill Area	Proc. Code	Description	Qty.	Amount
02/05/21	Med Pulmonary Medicine	95811	POLYSOMNOGRAPHY W/CPAP	1	469.00

Total Charges: 469.00

Professional Payments and Adjustments

Date	Description	Amount
04/14/21	HUMANA Payments	0.00
04/14/21	HUMANA Adjustments	-363.54

Total Payments: 0.00  
Total Adjustments: -363.54

Total Balance: 105.46





**Thank you for choosing UHealth for your health care needs.**

Our records indicate the balance on this statement is your responsibility.

Para asistencia en Español, por favor llame al 305-243-2900 de Lunes a Viernes 8:30 a.m.-5:00 p.m.

**Responsible Party:**

MENDOZA, JOSE E

**Active Insurance:**

HUMANA



**Pay Online**

[MyUHealthChart.com](http://MyUHealthChart.com)

You can ask billing questions, enroll in paperless statements, and request copies of your records all online.



**Pay by Phone**

Call 305-243-2900

8:30 a.m.-5:00 p.m. Monday through Friday



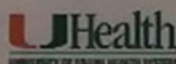
**Pay by Mail**

Complete the form below and return in the enclosed envelope.

**Account Summary**

Previous Statement Amount	\$5,156.85
New Services	\$469.00
Other Visit Activity	\$0.00
Insurance Paid/Adj	-\$363.54
You Paid	\$0.00
<hr/>	
Payment Plan Amount Due	\$214.87
Balance Due Not on Payment Plan	\$105.46
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<b>Current Amount Due</b>	<b>\$320.33</b>
<b>Due by Date</b>	<b>5/10/2021</b>

*Detach and return stub. Please make checks payable to University of Miami Health System.*

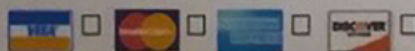


PO BOX 2978  
MUNCIE, IN 47307-0978

Electronic Service Requested

└ New address or insurance changes?  
Check here and update reverse side,  
or call customer service at 305-243-2900.

Pay online at [www.MyUHealthChart.com](http://www.MyUHealthChart.com)



Responsible Party: MENDOZA, JOSE E

**Current Amount Due: \$320.33**

Amount to Pay:

For credit card payments, see reverse →

University of Miami Health System  
P.O. Box 741199  
Atlanta, GA 30374-1199