



St. Joseph Mercy Hospital Ann Arbor  
 St. Joseph Mercy Hospital Livingston  
 St. Joseph Mercy Hospital Saline  
 P.O. Box 993, Ann Arbor, MI 48106-0993

**Important Message**

**Payment Options** - Pay your account by check or credit card over the phone by calling Customer Service or online (credit cards only) at SJMERCYHEALTH.ORG.

**Payment Arrangements** - We offer limited payment plans. If you cannot pay in full within 30 days, please call us. Making partial payments without contacting us may result in further collection activities.

**Account Summary**

**Patient Name** \_\_\_\_\_  
 Statement Date \_\_\_\_\_  
 Service Date \_\_\_\_\_  
 Type Of Service \_\_\_\_\_  
 Service Location \_\_\_\_\_  
**Account Number** \_\_\_\_\_  
 Total Charges \_\_\_\_\_  
 Total Payments/Adjustments \_\_\_\_\_  
 Current Account Balance \_\_\_\_\_  
 Amount Pending Insurance \_\_\_\_\_  
**Amount You Owe** \_\_\_\_\_

**Insurance Information**

We have billed the following insurances:  
 Insurance 1  
 Insurance 2

**Questions**

**Need help with your bill?** - We have Customer Service personnel to answer questions. We understand that healthcare expenses are sometimes unexpected. Financial Counselors can assist with payment plans, help you qualify for public assistance programs and our own McAuley Support. Call 734.712.3700 or 800.676.0437 for more information.

**Billing questions or changes in insurance coverage?**

Please call Customer Service  
 Monday - Friday: 8 a.m. – 6:30 p.m.

Local: 734.712.3700  
 Toll Free: 800.676.0437  
 Telecommunications Device for the Deaf  
 TDD 734.827.9336

*Please Note: Your physician may bill separately for their professional services.*

TRINITYST1-1



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**Statement Date:** 00/00/00

Patient Name	Account Number
_____	00000000-000
Amount Due	Amount Enclosed
\$ 0.00	\$ _____

**Please make check payable to St. Joseph Mercy Hospital and send with this payment stub to:**

**SAINT JOSEPH MERCY HEALTH SYSTEM**  
 P.O. BOX 371906  
 PITTSBURGH, PA 15250-7906

Check here if your address or insurance information has changed. Please indicate changes on the back of this page.

**To pay by credit card:** For your convenience, you may pay by Visa, MasterCard, Discover, or American Express. Please indicate your credit card preference, provide the account number, and sign below.



Account No. \_\_\_\_\_  
 Expiration Date \_\_\_\_\_  
 Signature X \_\_\_\_\_

Patient Name:  
Account Number:  
Attending Physician:

**Patient Services Provided**

LABORATORY	\$ 000.00
PHARMACY	\$ 000.00
MEDICAL SUPPLIES	\$ 00.00
<b>Total Charges</b>	<b>\$ 000.00</b>

**For Your Information**

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**Account Activity**

DESCRIPTION	AMOUNT
Patient Payments	\$ 0.00
Patient Adjustments	\$ 0.00
Insurance Payments/Adjustments	\$ 0.00



SAINT JOSEPH MERCY HEALTH SYSTEM  
A Member of Trinity Health

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REMARKABLE MEDICINE. REMARKABLE CARE.

**PLEASE COMPLETE IF YOUR ADDRESS OR INSURANCE HAS CHANGED**

**Address Change**

RESPONSIBLE PARTY NAME	HOME TELEPHONE	WORK TELEPHONE
ADDRESS	CITY	STATE ZIP

**Insurance Update**

POLICYHOLDER NAME	INSURANCE COMPANY NAME	GROUP POLICY PLAN NUMBER
POLICYHOLDER IDENTIFICATION NUMBER	CLAIM MAILING ADDRESS	
POLICYHOLDER'S DATE OF BIRTH	CITY	STATE ZIP
POLICYHOLDER'S RELATIONSHIP TO PATIENT	INSURANCE PHONE NUMBER	
POLICYHOLDER'S EMPLOYER NAME	DATES OF COVERAGE EFFECTIVE FROM:	EFFECTIVE TO: