MEMORIAL HOSPITAL OF RHODE ISLAND

111 BREWSTER STREET
PAWTUCKET, RI 02860

STATEMENT DATE	December 01, 2011
GUARANTOR NUMBER	987654321
GUARANTOR NAME	JANE DOE
DATE(S) OF SERVICE	03/01/12 - 03/10/12
BALANCE DUE NOW	$978.00

JANE DOE
1234 MAIN ST
PAWTUCKET, RI 02860-1234

IMPORTANT MESSAGE

Account Number	Regarding	Amount Owed	Service Date
0123456	Johnny Doe	100.00	03/01/12
1234567	Susan Doe	678.00	03/10/12

Our attempts to contact you regarding your unpaid balance have not been successful and we are writing this letter to request full payment today. Please respond within seven (7) days of this letter.

We ask that you phone our patient services department at (401) 729-2632 communicating your intentions. Our office hours are 8:00 AM to 5:00 PM Eastern Standard Time, Monday through Friday.

If you'd like to make a payment by phone, please call us at (401) 729-2632. Web payments can be made at **www.mhri.org.**

Sincerely,

Memorial Hospital of Rhode Island
(401) 729-2632

▼ Please return bottom portion with your payment ▼

❑ Please check box if above address is incorrect and indicate change(s) on reverse side.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ DISCOVER ☐ AMEX ☐ VISA

CARD NUMBER	CVV2	AMOUNT PAID
SIGNATURE		EXP. DATE

GUARANTOR NUMBER	STATEMENT DATE	AMOUNT DUE NOW
987654321	06/01/2012	**$978.00**

REGARDING
JANE DOE

You may pay your bill...

- Online at **www.mhri.org**
- By Phone at **(401) 729-2632**
- By Mail at the remit address below

MEMORIAL HOSPITAL OF RHODE ISLAND
111 BREWSTER STREET
PAWTUCKET, RI 02860

0001201234567 89 060110 00002000 01001

FOR CHANGE OF ADDRESS, MISSPELLINGS OR OTHER ERRORS, PLEASE PRINT CORRECTIONS.

Guarantor's Name			Phone # ( )
Guarantor's Address	City	State	Zip Code

IF YOU HAVE NOT SUPPLIED INSURANCE INFORMATION, PLEASE DO SO HERE:

PRIMARY INSURANCE COVERAGE	Patient's Relationship to Insured ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
Insurance Company Name	Phone # ( )
Insurance Company Address	
Policyholders Name	Birthdate / /
Policy & Group #	Policy Effective Date / /
Employer's Name	Phone # ( )
Employer's Address	

SECONDARY INSURANCE COVERAGE	Patient's Relationship to Insured ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
Insurance Company Name	Phone # ( )
Insurance Company Address	
Policyholders Name	Birthdate / /
Policy & Group #	Policy Effective Date / /
Employer's Name	Phone # ( )
Employer's Address	