UW School of Dentistry
1959 NE Pacific Street BOX 357131
Seattle, WA 98195-7131

PATIENT STATEMENT

AMOUNT NOW DUE	STATEMENT DATE	CHART NUMBER
-1,612.00	Jan 30, 2025	298252

ADDRESSEE:

557.973301.D1.1
JEANNE HOFFMAN
D3-292
321 HIGH SCHOOL RD NE
BAINBRIDGE ISLAND WA 98110-2647

☐ Please check if above address is incorrect and indicate changes

MAIL PAYMENT TO:

UW School of Dentistry
1959 NE Pacific Street BOX 357131
Seattle, WA 98195-7131

Check payable to: UW School of Dentistry

PLEASE DETACH AND RETURN THE TOP PORTION OF THIS RECEIPT WITH YOUR PAYMENT. RETAIN BOTTOM PORTION FOR YOUR RECORDS

DATE	PROC	TOOTH# SURF	PROCEDURE DESCRIPTION	TOTAL AMOUNT	EST. INS. PORTION	EST. PAT. PORTION
			Balance prior to: October 30, 2024	847.00	2,459.00	-1,612.00
Patient Name: Jeanne Hoffman					Chart Number: 298252	
				$0.00	$0.00	$0.00

Comments:
You can pay your bill online.
Join us at:
www.dental.uw.edu/pay<http://www.dental.uw.edu/pay>

TOTAL DUE	INS DUE	PATIENT DUE
847.00	**2,459.00**	**-1,612.00**

ABOUT YOUR STATEMENT

Patients are encouraged to pay their balances online here: www.dental.uw.edu/pay. Credit card payments via mail are no longer accepted. A patient is responsible for balance not paid by insurance. Please call 206-543-5297 if you have any questions related to your outstanding balance. Any and all correspondence concerning disputed debts, including any tender of a check or other written instrument as full satisfaction of a debt, must be sent to the SoD Office of Clinical Accounting, 1959 NE Pacific Street, Box 356365, Seattle, WA 98195-6365.

PATIENT IS RESPONSIBLE FOR BALANCE NOT PAID BY INSURANCE.

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

GUARANTOR: Jeanne Hoffman **Chart #** 298252

	CURRENT BALANCE	BAL. OVER 30 DAYS	BAL. OVER 60 DAYS	BAL. OVER 90 DAYS	BAL. OVER 120 DAYS	PAYMENTS RECEIVED AFTER STATEMENT CLOSING DATE ARE NOT REFLECTED ON THIS STATEMENT
PENDING INSURANCE	0.00	0.00	0.00	0.00	2,459.00	
PATIENT RESPONSIBILITY	-1,612.00	0.00	0.00	0.00	0.00	STATEMENT CLOSING DATE: Jan 30, 2025

Date Due:
Any comments or questions, please do not hesitate to contact us at 206-543-5297

AMOUNT DUE NOW: -1,612.00

557.973301.D1.1.1

PLEASE READ THE FRONT OF THIS FORM CAREFULLY BEFORE YOU COMPLETE ANY OF THIS INFORMATION!

CORRECTION OF PERSONAL INFORMATION

NAME		
ADDRESS		
CITY	STATE	ZIP
SOC. SEC NUMBER	PHONE ( )	
EMPLOYER'S NAME		
EMPLOYMENT ADDRESS		
CITY	STATE	ZIP
PHONE ( )		

INSTRUCTIONS FOR FILING HEALTH INSURANCE CLAIMS

1. If you wish our assistance in filing a claim for your health insurance benefits, please complete the form below and return it to our office. Failure to return the form automatically makes you responsible for payment in full.
2. If you need another claim filed for a second insurance company, please make a photocopy of the front and back of this statement, then complete one form for each insurance carrier. Return all forms to our office.
3. Be sure to sign the appropriate authorization(s) for each form submitted.

Complete all items below and return to our office.

Insurance Company ____________ Insurance Co Telephone No. ____________

Claim Office Address ____________

Policy Number ____________ Group Number ____________

Name of Insured ____________ Home Telephone Number ____________

Social Security No. ____________ Medicare No ____________ Medicaid No ____________

Employer Of Insured ____________ Employer's Telephone No ____________

Employer's Address ____________

Relation of Patient to Insured ____________ Patient's Date of Birth ____________

Was condition related to ☐ Employment ☐ Auto Accident Date of accident/injury ____________

Referring Physician ____________

X ____________
AUTHORIZED SIGNATURE DATE