The Brooklyn Hospital Center
*Keeping Brooklyn healthy.*

PO Box 8770
Coral Springs, FL 33075

**24/7 ACCESS**

**PAY ONLINE**
www.mymedpayment.com/brooklyn

**BY PHONE**
at 888-605-7180

**OR BY MAIL**
Use payment coupon below

## SUMMARY OF SERVICES AT: The Brooklyn Hospital Center

| Service Date: 05/13/2021 | |
|---|---|
| **Description** | **Amount** |
| LABORATORY | $1,390.79 |
| RADIOLOGY - DIAGNOSTIC | $910.76 |
| EMERGENCY ROOM | $2,045.63 |
| Total Payment and Adjustments | ($3,263.43) |
| **Total Balance Due** | **$1,083.75** |

## ACCOUNT SUMMARY

| |
|---|
| **PATIENT NAME:** Adela Ruffatti |
| **STATEMENT ID:** 96663327 |
| **ACCOUNT NUMBER:** 2105325763 |
| **BALANCE DUE: $1,083.75** |

## ACCOUNT STATUS

Statement Date - May 24 2021

Your account has a balance of $1,083.75. If you are unable to pay this amount in full, or have any questions, please contact Patient Financial Services.

If you have insurance coverage, please contact us immediately so that we can bill your carrier for you.

## Current Payment Arrangements

DUE UPON RECEIPT

## IMPORTANT INFORMATION

***Make checks payable (and mail) to:***
The Brooklyn Hospital Center
PO Box 13572
Philadelphia, PA 19101-3572

Federal guidelines prohibit us from disclosing any account information if you are not the patient or authorized representative. In order to discuss such information, the patient or authorized representative must provide consent.

## CONTACT INFORMATION

Patient Financial Services: **(Toll Free) 1-888-605-7180**
Hours: Mon. - Thurs. 8:00am - 9:00pm,
Fri. 8:00am - 5:00pm EST

To check your balance, make a payment, or request an itemized statement, 24 hour access is available through our automated system **(Toll Free) 1-888-605-7180**
OR **www.mymedpayment.com/brooklyn**

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT IN THE ENVELOPE PROVIDED

USPS USE ONLY
c/o The Brooklyn Hospital Center
PO Box 8770
Coral Springs, FL 33075

| |
|---|
| **PATIENT NAME:** Adela Ruffatti |
| **STATEMENT ID:** 96663327 |
| **ACCOUNT NUMBER:** 2105325763 |
| **BALANCE DUE: $1,083.75** |
| **ENCLOSED: $** _____ |

INI_1 ▲ 011105 B6

Adela Ruffatti
1385 Herkimer St Ph
Brooklyn NY 11233-3310

The Brooklyn Hospital Center
PO Box 13572
Philadelphia, PA 19101-3572

21053257630000010837 50P5

# Financial Assistance

The Brooklyn Hospital Center (TBHC) is committed to providing the best possible patient care to all who need it. TBHC has established a Financial Assistance Program (FAP) to provide assistance to qualifying patients.

Patients are eligible for financial assistance if

- They are uninsured or have exhausted their health insurance benefits
- They are residents of the United States
- Their family income is below 300% of the Federal Poverty Guidelines

## 2020 Federal Poverty Guidelines

The Brooklyn Hospital Center will determine a sliding fee scale for each service based on Federal Poverty Guidelines and the patient's income level as follows:

| Family Size | Poverty Guidelines |
|---|---|
| 1 | $12,760 |
| 2 | $17,240 |
| 3 | $21,720 |
| 4 | $26,200 |
| 5 | $30,680 |
| 6 | $35,160 |
| 7 | $39,640 |
| 8 | $44,120 |
| Over 8, add per person: | $4,480 |

**Please note, the Financial Assistance Program applies only to medically necessary services provided and billed by the hospital.** Cosmetic and any other services deemed not medically necessary are not eligible for financial assistance, fee waivers, discounts, or time payment plans.

The Financial Assistance Program does not apply to:

- Physician bills
- Patients enrolled in managed care or other insurance plans

Patients who may be eligible for other government sponsored health insurance programs, like Medicaid, may be asked to apply for these benefits. Our financial counselors can assist with this process.

PLEASE COMPLETE THE APPROPRIATE SECTIONS AND RETURN IN THE ENCLOSED ENVELOPE AS SOON AS POSSIBLE.

**CHANGE OF ADDRESS**

MY INFORMATION HAS CHANGED TO:

NAME

ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE

OTHER

**GOVERNMENT INSURANCE INFORMATION**

☐ Primary MEDICAID ☐ Secondary

Medicaid Card Number

Recipient ID Number

☐ Primary MEDICARE ☐ Secondary

Medicare Number

Retirement Date Medex Number

**OTHER INSURANCE INFORMATION**

☐ Primary ☐ Secondary

Ins. Co. Name & Plan Type (HMO/PPO/Etc.)

Ins. Co. Street Address

Ins. Co. City, State, & Zip

Policy/ID Number Effective Date

Subscriber Name Patient's Relationship to Subsc.

Employer City & State

Primary Care Physician Name & Tel. Number

**WORK RELATED INJURY OR ILLNESS**

Injury Date Case No.

Employer Name Employer Phone

Employer Street Address | City | State | Zip Code