



Statement of Services as of  
12/31/24

Patient Name: Robberto,Massimo  
Guarantor Number: 186402  
Statement Date: 12/30/24

Account Summary

Balance Due - You are not on a Payment Plan:  
\$95.00  
Amount Due: \$95.00

Financial Assistance

To talk with someone about financial assistance, please call us at 1 (855) 662-3017.

Questions about your bill?



Call 1 (855) 662-3017.  
Hours of Operation: 8:30am-4:30pm Mon-Fri



To send us a message use  
[mychart.hopkinsmedicine.org](mailto:mychart.hopkinsmedicine.org)  
Check our billing FAQs on MyChart.  
[Johns Hopkins Medicine MyChart Frequently Asked Questions](#) | [Johns Hopkins Medicine](#)

Payment Options

You can pay your bill securely at anytime using MyChart, your mobile device, or by mail.



To enroll in electronic statements, sign up for MyChart at  
[mychart.hopkinsmedicine.org](http://mychart.hopkinsmedicine.org)



To pay by phone call 1 (855) 662-3017 and select option 1.



To pay by mail, make your check payable to Johns Hopkins Medicine. Include the coupon and write your guarantor number in the check memo space.



Use your phone to scan the QR Code to pay your bill online or on the web at:

[MyChart - Pay as Guest  
\(hopkinsmedicine.org\)](http://MyChart-Pay as Guest(hopkinsmedicine.org))

Payment Plans

You can create or add to a payment plan by calling 1 (855) 662-3017.

Johns Hopkins Medicine

Johns Hopkins Medicine  
PO Box 3475  
Toledo, OH 43607-0475

DO NOT REMIT TO THIS ADDRESS

Statement Date:	Due Date:	Guarantor
12/30/24	01/29/25	Number: 186402

Amount Due: \$95.00

Amount Enclosed:



To pay easily and securely by credit card, go to [mychart.hopkinsmedicine.org](http://mychart.hopkinsmedicine.org) or call 1 (855) 662-3017.

## JOHNS HOPKINS MEDICINE

### PATIENT BILLING & FINANCIAL ASSISTANCE INFORMATION

#### YOUR RIGHTS AND RESPONSIBILITIES:

We make every effort to see that your account is properly billed. You are responsible for making sure the insurance information provided to us is correct. However, we cannot guarantee payment from your insurance company. All unpaid charges on the statement will be your responsibility.

If you have any questions concerning this bill and charges for services rendered by our hospitals and physicians, please call our Customer Service office between 8:30 AM to 4:30 PM, Monday through Friday at 443-997-3370 or toll-free at 1-855-662-3017. You can also contact us through your MyChart via the message center by selecting "Billing Question". If you do not have a MyChart Account, ask about it at your next appointment with your Johns Hopkins Medicine Provider. Questions regarding your account should include your service number or guarantor number, patient name, date of service, statement date, and insurance information.

If you are unable to pay your bill, you may be eligible for Financial Assistance. Financial Assistance applications can be obtained by contacting Customer Service between 8:30 AM to 4:30 PM, Monday through Friday. If you have additional questions, please refer to the JHM Hospital Information Sheet.

For Maryland Hospitals, if you have additional questions about your hospital bill or need assistance on how to file a complaint against a hospital, contact the Health Education and Advocacy Unit of the Office of the Attorney General at (877) 261-8807. For patients seen at Maryland Hospitals, the hospital is permitted to bill outpatients a fee, commonly referred to as the outpatient "facility fee". For additional information refer to the JHM Outpatient Facility Fee Acknowledgement Form.

Mail payments only to:  
Johns Hopkins Medicine  
P.O. Box 417714  
Boston, MA 02241-7714

Mail correspondence/insurance  
Information directly to Customer Service:  
3910 Keswick Road, Suite S-5100  
Baltimore, MD 21211

<http://mychart.hopkinsmedicine.org>

You will be able to view test results,  
access your health record, make  
appointments, review your statements,  
enroll to receive electronic statements and  
more through our secure online portal.

For Information concerning Maryland Medical Assistance Program contact your local Department of Social Services at 1-800-332-6347, TTY 1-800-925-4434 or visit: <https://health.maryland.gov/>

For Information concerning DC Medical Assistance Program contact your local Department of Social Services at 1-202-727-5355, TTY: 711 or visit: <https://dhcf.dc.gov/service/medicaid>

Payment remitted by check will be applied from oldest to newest account billed on this statement. If you wish to direct your payment to a specific account or accounts, you must do so by paying online at <http://mychart.hopkinsmedicine.org> or call 1-855-662-3017 and select option 1.

Any payment that is sent by check to Johns Hopkins Medicine for less than the full balance due that is marked "Paid in Full" or contains similar notation, or that is otherwise sent in full satisfaction of a disputed amount must be sent to the correspondence address listed above.

If any checks are returned due to NSF (Non-Sufficient Funds) or stop payment you will be charged the maximum fee permitted by law.

#### THIS STATEMENT INCLUDES BOTH HOSPITAL AND PHYSICIAN CHARGES.

#### CORRECTIONS OR CHANGE OF NAME, ADDRESS, OR HEALTH INSURANCE INFORMATION (Please Print)

Name Change:		New Street Address:	
City:	State:	Zip Code:	New Phone Number:
Insured's Name:	Patient's DOB:	Relationship to Insured (circle one): Self Spouse Child Other	
Insurance Company Name and Address:	Policy Number:	Group Number:	
Effective Date:		Insurance Company Phone Number:	
Signed:		Date:  I authorize the release of medical information necessary to process this claim. I assign and authorize direct payment to Johns Hopkins Health System of any insurance or other benefits otherwise payable to me or the patient	

## ACCOUNT DETAILS

Physician Services

Patient Name: Robberto,Massimo	THE JOHNS HOPKINS HOSPITAL
Service #: 69537193	Primary Payor: CIGNA
Outpatient	Secondary Payor:

**Important message about your account:** Our records show that you are now responsible for the service balance. Please make your payment today. Thank you for choosing Johns Hopkins Medicine for your healthcare needs.

Date	Description	Charges	Insurance Pmts/Adjs	Patient Pmts/Adjs	Patient Balance
Provider Name: Dunlap, Karen OD					
12/20/24	Eye Exam, Est Patient,Comprehesv	\$321.00			
12/20/24	Refraction	\$60.00			
12/30/24	Cigna Payments		\$167.54		
	Copay: \$35.00				
12/30/24	Cigna Adjustments		\$118.46		
	Service Total	\$381.00	\$286.00	\$0.00	\$95.00
Totals		\$381.00	\$286.00	\$0.00	\$95.00

**Subject:** Thank you for your payment!

**Date:** Wednesday, January 15, 2025 at 7:08:22 AM Eastern Standard Time

**From:** donotreply@hopkinsmedicine.org <donotreply@hopkinsmedicine.org>

**To:** robberto@me.com <robberto@me.com>

# Johns Hopkins Medicine

Thank you for your payment.

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Payment amount: **95.00**

Payment method: Visa x7355

Authorization code: 04206D

Payment date: January 15, 2025

View all statements and payments online by signing into [MyChart](#).  
Please call 855-662-3017 if you have any questions.