



Guarantor Name	Account Number	Statement Date
John Q Patient	11111111	06/17/2019

PAYMENT DUE

\$448.24

New Charges (Summary Below)	\$494.75
Adjustments	\$9.89
Amount Paid By You	\$0.00
Amount Paid By Insurance	\$36.62
Amount Due From You	\$448.24

CONTACT US FOR QUESTIONS ABOUT YOUR BILL
 (Llamanos si tiene preguntas sobre su factura)

 Call us : (866) 867-0178
 Monday - Thursday 8am-8pm
 Friday 8am-5pm

PATIENT NAME	ACCOUNT NUMBER	PRIMARY/SECONDARY INSURANCE	DATE	PROVIDER/LOCATION	SUMMARY	AMOUNT BILLED
M MEDICAL SERVICES						
JOHN Q PATIENT	11111111	CIGNA PAR/MIDLANDS/GR	07/02/2018	Oelwein Medical Center	RADIOLOGY	\$494.75
TOTAL PAYMENT DUE:						\$448.24

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

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

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

EMPLOYER'S NAME	TELEPHONE			
EMPLOYER'S ADDRESS	CITY	STATE	ZIP	

YOUR PRIMARY INSURANCE COMPANY'S NAME		EFFECTIVE DATE
PRIMARY INSURANCE COMPANY'S ADDRESS		PHONE
CITY	STATE	ZIP
POLICYHOLDER'S ID NUMBER		GROUP PLAN NUMBER
YOUR SECONDARY INSURANCE COMPANY'S NAME		EFFECTIVE DATE
SECONDARY INSURANCE COMPANY'S ADDRESS		PHONE
CITY	STATE	ZIP
POLICYHOLDER'S ID NUMBER		GROUP PLAN NUMBER