

RETURN SERVICE REQUESTED

TONY SAMPLE
 123 MAIN STREET
 SEATTLE, WA 98144

This is the name and address of the person responsible for payment of the bill.

If your insurance has changed or you have moved, please check this box and complete the information on the reverse side of the statement.

IF PAYING BY CREDIT CARD, COMPLETE ALL REQUESTED INFORMATION BELOW.

VISA MasterCard

CARD NUMBER _____ AMOUNT _____

SIGNATURE _____ EXP. DATE _____

STATEMENT DATE	ACCOUNT NO.	PAY THIS AMOUNT
05/03/07	12345678	2730.00

MAKE CHECK PAYABLE TO:

Amount owed.

PACIFIC MEDICAL CENTERS
 PO BOX C-34131
 SEATTLE, WA 98144

Please check box if address or insurance information is incorrect. Indicate changes on the reverse side, then detach and return this top portion with your payment.

SHOW AMOUNT PAID HERE \$

PRIMARY INSURANCE: REGENCE BLUE SHIELD

SECONDARY INSURANCE: MEDICARE

STATEMENT

DATE	SUMMARY OF SERVICES PROVIDED	CHARGE	ADJUSTMENT	PAYMENT	BALANCE
PATIENT NAME: TONY SAMPLE PREVIOUS BALANCE: 0.00					
03/28/07	8000024 PROVIDER: MARTY BABCOCK ARNP OFFICE VISIT	254.00			
03/28/07	OTHER SERVICES	140.00			
05/01/07	MEDICARE TRANSACTION		50.00	50.00	Invoice balance.
	Invoice number for services provided.	394.00	0.00	0.00	294.00
04/26/07	8000025 PROVIDER: RICHARD K WONDERLY MD OTHER SERVICES	2768.00			
05/01/07	MEDICARE TRANSACTION		50.00	50.00	
	Physician who provided service.	2768.00	0.00	0.00	2436.00

This is your patient account medical record number.

The aging of the balance is determined by the date of service to the date of the current statement.

ACCOUNT NUMBER	CURRENT	31 - 60 DAYS	61 - 90 DAYS	91 - 120 DAYS	OVER 120 DAYS	BALANCE DUE
12345678	2730.00	0.00	0.00	0.00	0.00	2730.00