



Return Mail Address
PO Box 441575, Detroit, MI 48244-1575

Please check box if address is incorrect or insurance information has changed, and indicate change(s) on the reverse side.

032413_MCRM_000009
JOHN J DOE
123 ANYWHERE ST
PORT HURON, MI 48060



IF PAYING BY MASTERCARD, VISA, OR DISCOVER FILL OUT BELOW		
CHECK CARD USING FOR PAYMENT		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARD NUMBER	CVV CODE	
SIGNATURE	EXP. DATE	
STATEMENT DATE 03/29/2013	PAY THIS AMOUNT \$855.00	ACCOUNT # 10050020

Amount Paid \$

MAKE CHECKS PAYABLE AND REMIT TO:

McLaren Macomb
P.O. Box 674351
Detroit, MI 48267-4351



0000002710006743510000000000010050020600000855000219102

****Please see reverse side for summary of charges****



Thank you for choosing McLaren Macomb for your healthcare needs.
Please detach and return top portion with your payment.

Date:	03/29/2013
Patient:	JOHN J DOE
Account:	10050020

Service Date:	02/19/2010
Balance:	\$855.00
Due Date:	04/19/2013

**FIRST NOTICE
PLEASE PAY UPON RECEIPT**

Thank you for choosing McLaren Macomb for your healthcare needs. The above balance represents your amount due. Please forward payment upon receipt.

We have convenient ways for you to pay: return the above payment coupon with your payment, contact us to pay by phone, or save time and postage and pay your bill on-line at www.mclaren.org/MacombPayYourBill. It's fast, easy and secure. Please make checks and money orders payable to McLaren Macomb and include your account number.

If you cannot pay this balance in full, please contact a customer service representative at one of the numbers listed below to discuss other options. Monthly payment options are available. Financial assistance is available to those who qualify. Applications available online at www.mclaren.org.

Sincerely,

Patient Account Representative
586-741-4845 or 877-765-8335
Mon - Fri, 8am - 5pm

Scan here to pay with mobile device.



To pay your bill online, please visit www.mclaren.org/MacombPayYourBill

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:

PRIMARY INSURANCE COVERAGE		Patient's Relationship to Insured <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		SECONDARY INSURANCE COVERAGE		Patient's Relationship to Insured <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	
Insurance Company Name		Phone # ()		Insurance Company Name		Phone # ()	
Insurance Company Address				Insurance Company Address			
Policy Holder's Name		Birthdate / /		Policy Holder's Name		Birthdate / /	
Policy & Group #		Policy Effective Date / /		Policy & Group #		Policy Effective Date / /	
Employee's Name		Phone # ()		Employee's Name		Phone # ()	
Employer's Address				Employer's Address			

Please see below for a breakdown of the services provided to you at our facility.

In the event you encounter any questions or concerns regarding your account, please contact us directly at the phone numbers listed on the first page of this mailing.

Once again, thank you for making our facility your health care provider of choice. We sincerely appreciate your business.

Patient:	JOHN J DOE
Admit Date:	02/19/2010

Date of Service:	02/19/2010
Date of Discharge:	02/19/2010

DESCRIPTION	AMOUNT
CARDIOVASCULAR	68.50
EMERGENCY CENTER	685.50
LABORATORY	101.00
TOTAL PAYMENTS	100.00
TOTAL ADJUST	6,546.00
BALANCE DUE	\$855.00