Statement

PATIENT NAME	IF PAYING BY CREDIT, FILL OUT BELOW. CHECK CARD USED
[redacted]	[ ] MASTER CARD [ ] VISA [ ] DISCOVER
BILL DATE: 07/29/2014 ACCT: 11525 AMOUNT PAID:	CARD NUMBER AMOUNT PAID
	SIGNATURE: EXP.DATE:
	AMOUNT ENCLOSED:

Claim Number

[redacted]

THIS IS A STATEMENT OF SERVICES RENDERED BY PHYSICIAN(S) WHO ARE MEMBERS OF:

MPS KOHLI MD SC
950 NORTH YORK RD SUITE 205
HINSDALE IL 605218609
630-952-1404

DATE OF SERVICE	DESCRIPTION OF SERVICE			AMOUNT
05/27/2014	Claim:13411, Provider: Maninder S Kohli, MD FACP			
05/27/2014	INIT HOSP-HI CPLX	516.00		
05/27/2014	HOSP SUB CARE-HI CPLX (05/28/2014)	263.00		
05/27/2014	HOSP SUB CARE-HI CPLX (05/29/2014)	263.00		
05/27/2014	HOSP SUB CARE-HI CPLX (05/30/2014)	263.00		
05/27/2014	HOSP SUB CARE-MOD CPLX (06/02/2014)	183.00		
05/27/2014	HOSP SUB CARE-MOD CPLX (06/03/2014)	183.00		
05/27/2014	HOSP DISC >30MIN (06/04/2014)	267.00		
06/20/2014	MEDICARE NGS Payment		638.39	
06/20/2014	MEDICARE NGS Adjustment		1123.76	
06/20/2014	MEDICARE NGS Withheld Amount		13.01	
06/27/2014	UNITED HEALTHCARE Payment		99.85	
06/27/2014	UNITED HEALTHCARE Payment		30.43	
07/29/2014	COINSURANCE			
	Your Balance Due On These Services ...			32.56

DATE	PATIENT NAME	ACCT. NO.	PAY THIS AMOUNT	32.56
07/29/2014	[redacted]	11525		

This is a statement for professiona[redacted]rvices rendered by your physician. You [redacted]ceive a separate bill from the hospital for [redacted]ervices.

MAKE [redacted]ECK PAY[redacted]TO: MPS KOHLI SC

IMP[redacted]RTANT MESSAGE REGARI[redacted]NG YOUR ACCOUNT

Patient Lastname, Firstname

Patient Account Number

Payment Amount to Pay