

MAKE CHECKS PAYABLE TO:



PO Box 650426
Dallas, TX 75265-0426

Patient Name: **ROBERT PLOCK**
ADDRESSEE:

RETURN SERVICE REQUESTED 10 1

10096120
T911211**
ROBERT PLOCK
6827 LATTA PKWY
DALLAS, TX 75227-6043

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

STATEMENT

TO ENSURE PROPER CREDIT, DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT.

Your healthcare provider is now part of US Anesthesia Partners. Thank you for choosing us for your healthcare needs.

Your insurance company has processed your claim and the balance is now your responsibility. The outstanding balance is now due. Please pay this amount in full today. If you have questions please call our billing office at (972) 663-8520.

ACCOUNT ACTIVITY:

Date	Provider	Description	Charge	Pay/Adj	Balance
05/29/13	RACZ	64483 / NJX STR TFR E LMB	\$5024.00		
06/25/13		UHC PMT		\$0.00	
06/25/13		DEDUCTIBLE AMOUNT			
06/25/13		HMO/PPO ADJ		\$4458.74	
05/29/13	ZACEK	01936 /5 PERC IMG GUID S	\$959.00		\$565.26
07/09/13		UHC PMT		\$159.36	
07/09/13		DEDUCTIBLE AMOUNT			
07/09/13		COINSURANCE AMOUNT			
07/09/13		HMO/PPO ADJ		\$296.60	
07/03/13	RACZ	64483 / NJX STR TFR E LMB	\$5024.00		\$503.04
07/29/13		UHC PMT		\$395.68	
07/29/13		COINSURANCE AMOUNT			
07/29/13		HMO/PPO ADJ		\$4458.74	
07/03/13	ZACEK	01936 /5 PERC IMG GUID S	\$822.00		\$169.58
08/21/13		UHC PMT		\$396.48	
08/21/13		COINSURANCE AMOUNT			
08/21/13		HMO/PPO ADJ		\$255.60	
08/07/13	RACZ	64483 / NJX STR TFR E LMB	\$5024.00		\$169.92
09/04/13		UHC PMT		\$395.68	
09/04/13		COINSURANCE AMOUNT			
09/04/13		HMO/PPO ADJ		\$4458.74	
		PATIENT BALANCE DUE			\$169.58

CONTINUED on next page...

CONTACT US:

We gladly accept (please mark box).

<input type="checkbox"/> DISCOVER	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA	<input type="checkbox"/> AMERICAN EXPRESS
NAME ON CARD		SECURITY CODE	
CARD NUMBER		EXP. DATE	
SIGNATURE		AMOUNT PAID	
ACCOUNT #	BILLING DATE	BALANCE DUE NOW	
2341966	12/01/14	CONTINUED	

ANY PAYMENTS AND CHARGES AFTER THE ABOVE DATE WILL APPEAR ON THE NEXT STATEMENT

REMIT TO:

US ANESTHESIA PARTNERS
PO BOX 650426
DALLAS TX 75265-0426



ACCOUNT SUMMARY:

Patient Name
Account Number
Statement Date

Total Charges
Insurance Payments (-)
Insurance Adjustments (-)
Patient Payments (-)
Patient Adjustments (-)

Insurance Pending
Patient Balance

PLEASE PAY THIS AMOUNT:

CURRENT INSURANCE INFORMATION:

Primary
Name
Member / ID Number

Secondary
Name
Member / ID Number

For billing questions or an itemized list of charges, please call us at 972-663-8520. Our office hours are 8:30 A.M. through 5:00 P.M., Monday – Friday. Please see the back side of this statement for more information.

Written communication regarding any disputed bill, including an instrument tendered as full satisfaction of the bill, must be sent to:
13737 Noel Rd., Suite 1400, Dallas, TX 75240 ATTN: ACCOUNT DISPUTE RESOLUTION

