

006030 603001

0001694L

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.

MOUNT CARMEL HEALTH PROVIDERS

Dept. 810
Columbus OH 43265-0810

2400K

CHECK CARD USING FOR PAYMENT

MASTERCARD
 DISCOVER
 VISA
 AMERICAN EXPRESS

CARD NUMBER: _____ AMOUNT: _____

SIGNATURE: _____ EXP. DATE: _____

FOR BILLING INQUIRIES, PHONE: (614) 234-9191
OR 1-800-234-0015

STATEMENT DATE
12/04/02

PAY THIS AMOUNT
47.00

ACCT. #
204451

CALL MON-FRIDAY 7:30 AM-4:30 PM
or visit www.mchealthproviders.com

PAGE 001

SHOW AMOUNT
PAID HERE \$

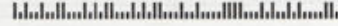
ADDRESSEE:

REMIT TO:

PATIENT HEALTH PROVIDERS
6400 E BROAD ST
ATTENTION:CBO 2ND FLOOR
COLUMBUS OH 43213

MOUNT CARMEL HEALTH PROVIDERS

Dept. 810
Columbus OH 43265-0810



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

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE	DESCRIPTION	PATIENT	CHARGES	INSURANCE RECEIPTS	PATIENT RECEIPTS	ADJUSTMENT	BALANCE	INS
11/06/02	ESTABLISHED OFFICE VISIT LOW C Mt.Carmel Doctor	Patient	65.00	.00	.00	.00	65.00	X
12/02/02	ESTABLISHED OFFICE VISIT S.F. Mt.Carmel Doctor	Patient	47.00	.00	.00	.00	47.00	

Statement Due Upon Receipt

CURRENT MO.	30 - 60 DAYS	60 - 90 DAYS	90 - 120 DAYS	OVER 120 DAYS	ACCOUNT BAL.	*INS PENDING	PATIENT DUE
47.00	.00	.00	.00	.00	112.00	65.00	47.00

DATE: 12/04/02

ACCOUNT:

204451