McLaren OAKLAND

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

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

CHECK CARD USING FOR PAYMENT

☐ MasterCard ☐ VISA ☐ DISCOVER ☐ AMERICAN EXPRESS

CARD NUMBER	CVV CODE	AMOUNT

SIGNATURE	EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT #
03/29/2013	$855.00	10050020

Amount Paid $

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

032413_POHR_000009
JOHN J DOE
123 ANYWHERE ST
PORT HURON, MI 48060

MAKE CHECKS PAYABLE AND REMIT TO:

McLaren Oakland
8600 Reliable Pkwy
Chicago, IL 60686-0086

Patient Name:
JOHN J DOE

Please see reverse side for summary of charges

Thank you for choosing McLaren Oakland 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 WITHIN 21 DAYS

Thank you for choosing McLaren Oakland for your healthcare needs. The above balance represents your amount due. Please forward payment within 21 days.

We have many 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/OaklandPayYourBill. It's fast, easy and secure. Please make checks and money orders payable to McLaren Oakland 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
248-338-8505 or 877-765-7452
Mon - Fri, 8am - 5pm

Scan here to pay with mobile device.

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

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 ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	**SECONDARY INSURANCE COVERAGE**	Patient's Relationship to Insured ☐ SELF ☐ SPOUSE ☐ CHILD ☐ 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***