BRYAN HEART
1600 SOUTH 48TH SUITE 600
LINCOLN, NE 68506-1275
PERSONAL & CONFIDENTIAL

ADDRESS SERVICE REQUESTED

0101

IF PAYING BY CREDIT CARD, PLEASE CHECK BOX FOR SELECTION AND FILL OUT BELOW.

☐ MASTERCARD ☐ VISA

CARD NUMBER	VERIFICATION #
CARDHOLDER NAME	EXP. DATE
SIGNATURE	

ACCOUNT NUMBER	DUE DATE	Amount Due	AMOUNT PAID
xxxxxx	01/26/2018	$50.00	

Stmt Date: 01/11/2018

Patient Name
Patient Address

BRYAN HEART
PO BOX 82653
LINCOLN, NE 68501-2653

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

TO ENSURE PROPER CREDIT, DETACH AND RETURN TOP PORTION IN THE ENCLOSED ENVELOPE.

Page	Statement Date	Due Date	Office Phone Number	Account #	Patient Balance
1 of 1	01/11/2018	01/26/2018	(402) 483-3355	xxxxxx	$50.00

Date	Visit Detail	Explanation of Activity	Charges & Debits	Insurance Pending	Payments & Credits	Patient Balance
Patient: Patient Name						
Voucher: #######						
12/12/2017		Office/Outpatient Visit	$150.00			
01/08/2018		BCBS Payment			-$50.00	
01/08/2018		BCBS Adjustment			-$100.00	
01/08/2018		BCBS Transfer				
		Your Co-Pay is due at time of service. Please remit payment.				
		Visit Total				**$50.00**

Please call 402-483-3355 to inquire about Financial Assistance eligibility

MESSAGE

Your prompt payment is greatly appreciated.

BRYAN HEART
1600 SOUTH 48TH SUITE 600
LINCOLN, NE 68506-1275

Account Number	xxxxxx
Billing Inquiries	(402) 483-3355
Amount Due	**$50.00**

2738-ALLST7-187958-1239731056-; 5973410-1-132; 1239731056_4; 1

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE . . . .

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE
( )

MARITAL STATUS
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME TELEPHONE
( )

EMPLOYER'S ADDRESS CITY STATE ZIP

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

PRIMARY INSURANCE COMPANY'S ADDRESS PHONE

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

SECONDARY INSURANCE COMPANY'S ADDRESS PHONE

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

The purpose of this communication is to collect a debt, and any information obtained will be used for that purpose.