






Patient Name
 and Account
 Number
 Needed to
 Enroll

PATIENT NAME		AMOUNT DUE
SAMPLE A SAMPLE		41.00
ACCOUNT NUMBER	DATE	AMOUNT PAID
02134784	04/19/09	
<input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> 		
Card Holder Name		3 Digit Security Code (Required)
Card Number		Exp Date
Signature		

Statement
 Date and
 Amount Due
 Needed to
 Enroll

02134784
 SAMPLE A SAMPLE
 321 ANY STREET
 Mentor, OH 44060-0905


University Hospitals Medical Group
 PO Box 74116
 Cleveland OH 44194-4116


02134784000041008

Please detach here and return the top portion with your payment

DATE	DESCRIPTION OF SERVICE	ACCOUNT ACTIVITY	PATIENT DUE
	PETER C YOUNG MD		
02/04/05	X-RAY EXAM OF LOWER SPINE	41.00	
03/28/05	MEDICAL MUTUAL PAYMENT	0.00	
06/16/05	MEDICAL MUTUAL PAYMENT	0.00	
10/11/06	MEDICAL MUTUAL PAYMENT	0.00	
	BALANCE DUE		