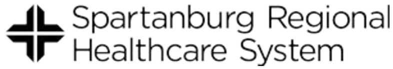
000004



2421 Brookstone Centre PKWY
Columbus GA 31904-4501
Return Service Requested

(800)749-2940

ACCOUNT NUMBER	PATIENT NAME	AMOUNT ENCLOSED
STATEMENT DATE	**AMOUNT DUE**	
10/30/2023	$109.80	$

CHECK CARD USING FOR PAYMENT

☐ VISA ☐ MasterCard ☐ DISCOVER ☐ American Express

CARD NUMBER	CID
AMOUNT	EXP DATE (MM/YYYY)
SIGNATURE	

MAKE CHECK PAYABLE AND REMIT TO:

SPA10X 4195409 437616682

EASLEY, SC 29642-8005

Spartanburg Medical Center
MGC - Anesthesiology
PO BOX 746639
Atlanta GA 30374-6639

☐ CHECK HERE IF ADDRESS OR INSURANCE INFORMATION IS INCORRECT AND INDICATE CHANGE ON REVERSE SIDE

STATEMENT

DETACH HERE AND RETURN TOP PORTION WITH YOUR PAYMENT

ACCOUNT NUMBER	PATIENT NAME	STATEMENT DATE
		10/30/2023

DATE	DESCRIPTION	CHARGES	PAYMENTS
08/09/2023	ANESTHESIA SERVICES	$1,755.00	
08/22/2023	BILLED $1755.00 TO COMMERCIAL GENERIC		
10/30/2023	INSURANCE PAYMENT BY COMMERCIAL GENER		$439.20
10/30/2023	CONTRACTUAL ADJUSTMENT BY COMMERCIAL		$1,206.00

*** * * MESSAGES * * ***

DUE TO THE RECENT ACTIVITY ON YOUR ACCOUNT, THIS BALANCE IS YOUR RESPONSIBILITY. PLEASE REMIT PAYMENT WITHIN 15 DAYS.

PAY CHECKS TO: MEDICAL GROUP OF THE CAROLINAS-ANESTHESIOLOGY

PLEASE CONTACT OUR BILLING OFFICE AT (800) 749-2940 TO PAY BY CREDIT CARD, OR PROVIDE ON STATEMENT AND RETURN.
** NOT INCLUDED IN MYCHART ** EMAIL LAKESHA.DAVISON@MYBILLINGGUY.COM FOR BILLING QUESTIONS LAKESHA DAVISON. (800) 749-2940, EXT. 113

Total Charges	**$1,755.00**
Total Payments	**$439.20**
Total Adjustments	**$1,206.00**
Total Due	**$109.80**

Spartanburg Medical Center
MGC - Anesthesiology
PO BOX 746639
Atlanta GA 30374-6639

(800)749-2940

PLEASE COMPLETE THE INFORMATION BELOW AND RETURN TO OUR BILLING OFFICE FOR PROCESSING.

CHANGE OF ADDRESS / CHANGE OF TELEPHONE

STREET:		
CITY:	STATE:	ZIP:
TELEPHONE NUMBER:		

INSURANCE INFORMATION / CHANGE OF INSURANCE

PATIENT NAME:		MARITAL STATUS:
TYPE OF INSURANCE: (BLUE CROSS / BLUE SHIELD, MEDICARE, MEDICAL ASSISTANCE / MEDI-CAL / MEDICAID, WELFARE, PUBLIC ASSISTANCE, WORKER'S COMPENSATION, HMO, PPO, TRICARE, ACTIVE DUTY MILITARY, INDEMNITY OR OTHER BASIC HEALTH INSURANCE.)		
INSURANCE COMPANY NAME:		
INSURANCE COMPANY ADDRESS:		CITY / STATE / ZIP:
CARDHOLDER / INSURED'S NAME:		RELATIONSHIP TO PATIENT: (CIRCLE ONE) SELF - SPOUSE - CHILD - OTHER
POLICY #:	GROUP #:	EFFECTIVE DATE OF INS.
INSURED'S EMPLOYER:		BUSINESS PHONE #: