TEAR OFF AND RETURN WITH PAYMENT

Statement Date
5/24/2011

AHHPC
1055 Westgate Drive Suite 100
St Paul, MN 55114-1451
651-635-9173

Charges or Payments received after this date will appear on next statement.
Circle one: VISA MasterCard DISCOVER AMERICAN EXPRESS

Card Number ______________________ SIC __________

Amount Authorized ______________ Exp. Date __________

Signature ____________________________________

Program: HOSP
Division: AHHPC

AMOUNT ENCLOSED $ ______________________

Test, John
222 Second St NE
East Bethel, MN 55011

Acct#: 000000000119117
Admit Date: 2/15/2010 Disch Date: 3/1/2010
Patient ID: 000000000156446 MRN: 9999999999

Date	For: Test, John		Amount
	Self Pay		
	201002-1046	*02/2010-SELF PAY*	
4/8/2010	Inv	02/2010-SELF PAY	223.37
			223.37
	201003-1018	*03/2010-SELF PAY*	
5/6/2010	Inv	03/2010-SELF PAY	15.94
			15.94

Patient responsibility charges are determined by your insurance company.

Current	61-120	121-270	271-365	366+	Please Pay This Amount
0.00	**0.00**	**0.00**	**0.00**	**239.31**	**239.31**