STATEMENT

THIS IS A STATEMENT OF SERVICES RENDERED BY PHYSICIAN(S) WHO ARE MEMBERS OF:

Center For Adult Healthcare SC 303 East Army Trail Road Suite 301 Bloomingdale, IL60108-2169 630-893-0347

	PATIENT NAME	
AUpgrade Te	st	
BILL DATE	ACCOUNT NO.	AMOUNT PAID
04/03/2015	12270	

Claim Number

AUpgrade Test 1111 Cornerway Street Georgia AR 60506

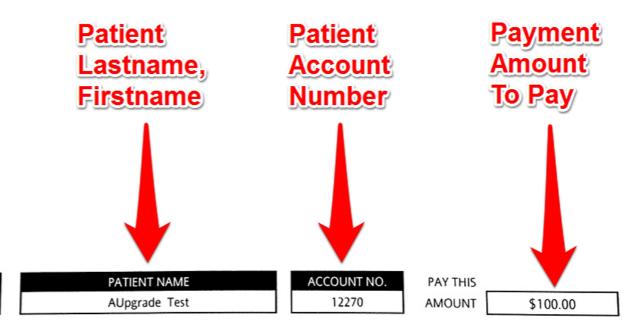
This is a statement for professional services rendered by your physician. You may receive a separate bill from the hospital for its services.

DATE OF SERVICE DESCRIPTION OF SERVICE AMOUNT

03/16/2014 Claim:9230, Provider: Mandeep Kohli, DO
03/16/2014 Facility: Center For Adult Healthcare SC
03/16/2014 AUDITOR EVOKE POTENT, COMPRE

Your Balance Due On These Services... 100.00

100.00



MAKE CHECK PAYABLE TO:

DATE

04/03/2015

Center for Adult Healthcare SC

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

We are pleased to offer	you the option of c	redit card payment. Pleas	se indicate your method I	pelow.	
Payment Method:	VISA	MASTER CARD	DISCOVER	AMEX	CHECK
Amount:			Exp. Date:		
Credit Card No:			Date:		
Signature:			CVV:		