Manhattan Medical Group
PO Box 803
Manhattan, KS 66505

IF PAYING BY VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS, FILL OUT BELOW		
☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMER. EXP.		
CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

Patient Name: Test Test
Billing Phone:785-370-0189
Office Hours: Monday-Thursday 8:00am-5:00pm

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
04/27/2021	0.01	32927

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT PAID HERE $

161723 - 1

TEST TEST
1 TEST,TEST
NY AA 12343

000001

MAKE CHECKS PAYABLE / REMIT TO:

Manhattan Medical Group
PO BOX 803
MANHATTAN KS 66505-0803

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

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT IN ENCLOSED ENVELOPE

DATE	DESCRIPTION	CHARGES	PAYMENTS / ADJUSTMENTS	AMOUNT DUE
04/27/2021	Claim:119217	0.01		0.01

DATE	PATIENT NAME	ACCOUNT NO	BALANCE DUE
04/27/2021	Test Test	32927	0.01

If you would like to pay your bill through the patient portal, call us at 785-370-0189 to request access. You may still pay by mail using the enclosed envelope or pay by phone by calling the billing department at 785-370-0189, Monday-Thursday, 8am-5pm.

IF WE DO NOT HAVE YOUR INFORMATION, OR IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

PATIENT INFORMATION

Your Name (Last, First, Middle Initial)		Date of Birth
Address		
City	State	Zip
Telephone ( )		
Social Security #		
Employer's Name		Telephone ( )
Employer's Address		
City	State	Zip
Please Indicate if Applicable: ❑ AUTO ACCIDENT ❑ WORKER'S COMPENSATION		Date of Injury

INSURANCE INFORMATION

Your **PRIMARY** Insurance Company's Name		
Primary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number		Group Plan Number
Your **SECONDARY** Insurance Company's Name		
Secondary Insurance Company's Address		
City	State	Zip
Policyholder Name	Date of Birth	Sex
Policyholder's ID Number		Group Plan Number