

Abrazo Arrowhead Campus

PAYMENT DUE
\$15,312.43

PATIENT NAME	PATIENT REF. NO.	SERVICE DATE(S)	DUE DATE
JANET ANDERSON	[REDACTED]	04/11/2025 - 04/12/2025	Due Upon Receipt

This is your Abrazo Arrowhead Campus bill.

Hi, JANET! Thank you for trusting us with your healthcare needs. We do not have insurance on file for your account and the amount listed above is your responsibility.

YOUR NEXT STEP

Make Payment with options below



SET UP A PAYMENT PLAN

Visit <https://www.abrazohealth.com/abrazo-arrowhead-campus/PayMyBill> or call 1(855)589-9912; TTY: 711 Monday - Friday 7:30am to 7:00pm to select a payment plan option. Hospital Code: 730



FINANCIAL ASSISTANCE

If you are unable to pay your bill at this time, you may qualify for financial assistance or other government assistance programs. Please contact Eligibility and Enrollment Services (EES) at 1(888)233-7868, Monday to Friday, 7:00am - 6:30pm CT for more information.



CONTACT CUSTOMER SERVICE

For payment assistance or to provide insurance information for billing contact us at 1(855)589-9912; TTY: 711 Monday - Friday 7:30am to 7:00pm.

See reverse for Frequently Asked Questions & Important Information 

Detach section below and return with your payment.



PO BOX 1259
DEPT # 148905
OAKS, PA 19456



PAY ONLINE AT
<https://www.abrazohealth.com/abrazo-arrowhead-campus/PayMyBill>

JANET ANDERSON



Check if address/insurance changes are on back.

IF PAYING BY CREDIT/DEBIT CARD

VISA MASTERCARD AMERICAN EXPRESS DISCOVER

CARD NUMBER SECURITY CODE EXP DATE

SIGNATURE

CARDHOLDER NAME

CARDHOLDER PHONE #

BILLING DATE

PATIENT REF. NO.

DUE DATE

04/24/2025

[REDACTED]

Due Upon Receipt

AMOUNT DUE

AMOUNT PAID

\$15,312.43

PLEASE MAKE CHECKS PAYABLE TO:
Abrazo Arrowhead Campus
P.O. BOX 745823
Los Angeles CA 90074-5823



Abrazo Arrowhead Campus

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CHARGE(S) INCLUDED:

SPECIAL CARE UNIT	\$8,146.00
LABORATORY SERVICES	\$8,147.00
EKG SERVICES	\$5,532.00
DIAGNOSTIC/THERAPEUTIC IMAGING	\$35,302.00
PHARMACY	\$2,054.00

Total Charges:	\$59,181.00
Insurance Adjustments:	\$43,868.57
Amount Insurance Paid:	\$0.00
Additional Payment Due From Insurance:	\$0.00
Your Previous Payments:	\$0.00

Balance You Owe Now: \$15,312.43

PRIMARY INSURANCE:

Insurance Name	SELF PAY/CONTINUUM OF CARE
ID Number	

SECONDARY INSURANCE:

Insurance Name	NONE ON FILE
ID Number	NONE ON FILE

