



Peak Vista Community Health Centers
 Dept 1565
 PO Box 30106
 Salt Lake City, UT 84130-0106

IF PAYING BY CREDIT CARD, PLEASE FILL OUT BELOW.
 CHECK CARD USING FOR PAYMENT

MASTERCARD DISCOVER VISA AMERICAN EXPRESS

CARD NUMBER	EXP. DATE	SECURITY CODE
SIGNATURE		SHOW AMOUNT PAID HERE \$
STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT #
RD02	RD04	RD01

CHANGE SERVICE REQUESTED

ADDRESSEE:

IMBIDSN
 NAME1
 NAME2
 NAME3
 NAME4
 NAME5



Invoice Number: RD03
 For all billing questions, call: 719-344-6444

MAKE CHECKS PAYABLE / REMIT TO:

Peak Vista Community Health Centers
 Dept 1565
 PO Box 30106
 Salt Lake City, UT 84130-0106



STATEMENT

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

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

Date	Procedure Code	Description	Charges	Credits	Insurance Balance	Patient Balance
L0101	L0102	L0103	L0104	L0105	L0106	L0107
L0201	L0202	L0203	L0204	L0205	L0206	L0207
L0301	L0302	L0303	L0304	L0305	L0306	L0307
L0401	L0402	L0403	L0404	L0405	L0406	L0407
L0501	L0502	L0503	L0504	L0505	L0506	L0507
L0601	L0602	L0603	L0604	L0605	L0606	L0607
L0701	L0702	L0703	L0704	L0705	L0706	L0707
L0801	L0802	L0803	L0804	L0805	L0806	L0807
L0901	L0902	L0903	L0904	L0905	L0906	L0907
L1001	L1002	L1003	L1004	L1005	L1006	L1007
L1101	L1102	L1103	L1104	L1105	L1106	L1107
L1201	L1202	L1203	L1204	L1205	L1206	L1207
L1301	L1302	L1303	L1304	L1305	L1306	L1307
L1401	L1402	L1403	L1404	L1405	L1406	L1407
L1501	L1502	L1503	L1504	L1505	L1506	L1507
L1601	L1602	L1603	L1604	L1605	L1606	L1607
L1701	L1702	L1703	L1704	L1705	L1706	L1707
L1801	L1802	L1803	L1804	L1805	L1806	L1807
L1901	L1902	L1903	L1904	L1905	L1906	L1907
L2001	L2002	L2003	L2004	L2005	L2006	L2007
L2101	L2102	L2103	L2104	L2105	L2106	L2107
L2201	L2202	L2203	L2204	L2205	L2206	L2207
L2301	L2302	L2303	L2304	L2305	L2306	L2307
TOTAL DUE					RD11	RD12

RD31
 RD32
 RD33
 RD34
 RD35

Pay Online Here



	CURRENT	30 DAYS	60 DAYS	90 DAYS	OVER 120 DAYS
PATIENT BALANCE	RD21	RD22	RD23	RD24	RD25
INSURANCE BALANCE	RD26	RD27	RD28	RD29	RD30

You have a balance due. To remit payment, we encourage you to enroll in MyChart, our online patient portal.

Invoice Number: RD03
 Office Hours: Monday-Friday 8am - 5pm
 Billing Phone Number: 719-344-6444
 Website: <https://www.peakvista.org/>

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

PATIENT INFORMATION

INSURANCE INFORMATION

Your Name (Last, First, Middle Initial)			Date of Birth			Your PRIMARY Insurance Company's Name			
Address						Primary Insurance Company's Address			
City		State		Zip Code		City		State	Zip Code
Telephone ()			Social Security Number			Policyholder's Name		Date of Birth	Sex
Employer's Name			Telephone ()			Policyholder's ID Number		Group Plan Number	
Employer's Address						Your SECONDARY Insurance Company's Name			
Employer's City		Employer's State		Employer's Zip Code		Secondary Insurance Company's Address			
Please indicate if applicable: <input type="checkbox"/> Auto Accident <input type="checkbox"/> Worker's Compensation						City		State	Zip Code
						Policyholder's Name		Date of Birth	Sex
Date of Injury						Policyholder's ID Number		Group Plan Number	