Mary Free Bed
Orthotics & Prosthetics + Bionics
235 Wealthy St. SE
Suite #1100
Grand Rapids, MI 49503
RETURN SERVICE REQUESTED

Patient Account Number	Patient Name	Service Location	Prescription ID	Amount Due
001	Patient Name		001	1977.31

ADDRESSEE:

186150 - 1

Patient Name
Patient Address

000001

MAKE CHECKS PAYABLE TO:

Mary Free Bed Orthotics & Prosthetics + Bionics
235 Wealthy St. SE
Suite #1100
Grand Rapids, MI 49503

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

PLEASE DETACH AND RETURN ABOVE WITH YOUR PAYMENT

STATEMENT

Patient Name

Statement Date 09/10/2024

Account Number 001

Code	Description	Unit Price	Quantity	Total Charges
L5301	BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT, EN	5002.98	1	5002.98
L5620	ADDITION TO LOWER EXTREMITY, TEST SOCKET, BELO	553.57	2	1107.14
L5629	ADDITION TO LOWER EXTREMITY, BELOW KNEE, ACRYLI	590.01	1	590.01
L5637	ADDITION TO LOWER EXTREMITY, BELOW KNEE, TOTAL	715.13	1	715.13
L5645	ADDITION TO LOWER EXTREMITY, BELOW KNEE, FLEXI	1819.16	1	1819.16
L5671	ADDITION TO LOWER EXTREMITY, BELOW KNEE / ABOV	923.49	1	923.49
L5673	ADDITION TO LOWER EXTREMITY, BELOW KNEE/ABOVE	1467.67	2	2935.34
L5910	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ALI	672.41	1	672.41
L5940	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ULT	931.28	1	931.28
L5976	ALL LOWER EXTREMITY PROSTHESES, ENERGY STORIN	1097.41	1	1097.41
L8400	PROSTHETIC SHEATH, BELOW KNEE, EACH	29.22	6	175.32

PAY THIS AMOUNT

Please Pay	Please Pay By
1977.31	10/05/2024

IMPORTANT MESSAGE:

Thank you for choosing Mary Free Bed Orthotics & Prosthetics + Bionics
To pay online, scan QR code.

PAYMENT OPTIONS

Mail the payment using the slip above

Billing Phone: 616-840-8685 Office Hours: M-TH 8am-5pm, F 8am-3pm

To Pay Online: https://www.patientnotebook.com/maryfreebedrehabilitation/

186150-1-23320283

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

"DETACH HERE AND RETURN ABOVE STUB"

Code	Description	Unit Price	Quantity	Total Charges
L8420	PROSTHETIC SOCK, MULTIPLE PLY, BELOW KNEE, EACH	38.95	6	233.70
L8440	PROSTHETIC SHRINKER, BELOW KNEE, EACH	87.05	2	174.10
L8470	PROSTHETIC SOCK, SINGLE PLY, FITTING, BELOW KNEE	12.40	6	74.40

Total Charges	Total Adjustments	Total Guarantor Paid	Total Insurance Paid
16451.87	-6231.55	100.00	8143.01