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:	MAKE CHECKS PAYABLE TO:		

Patient Name Patient Address 000001

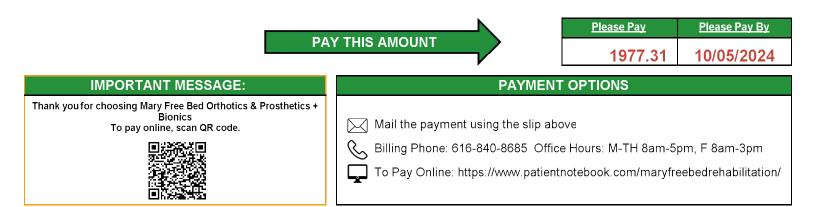
MAKE CHECKS PAYABLE TO:

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		<u>ent Date</u>)/2024	<u>Account Number</u> 001			
<u>Code</u>	Description	<u>Unit Price</u>	<u>Quantity</u>	<u>Total</u> <u>Charges</u>		
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		



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

PATIENT INFORMATION		,	INSURANCE INFORMATI	ON	
Your Name (Last, First, Middle Initial)	Date of Birth		Your PRIMARY Insurance Company's Na	ame	
Address			Primary Insurance Company's Address		
City S	itate	Zip	City	State	Zip
Telephone			Policyholder Name	Date of Birth	Sex
Social Security #			Policyholder's ID Number	Group Plan Numb	per
Employer's Name	Telephone ()		Your SECONDARY Insurance Company's	s Name	
Employer's Address			Secondary Insurance Company's Addres	s	
City S	State	Zip	City	State	Zip
Please Indicate if Applicable:	Date of Injury		Policyholder Name	Date of Birth	Sex
AUTO ACCIDENT WORKER'S COMPENSATION			Policyholder's ID Number	Group Plan Numb	per

"DETACH HERE AND RETURN ABOVE STUB"

<u>Code</u>	Description	<u>Unit Price</u>	<u>Quantity</u>	<u>Total</u> <u>Charges</u>
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



