

CITY OF LONG BEACH 333 West Ocean Blvd. Long Beach, CA 90802-4604 EMERGENCY AMBULANCE SERVICE MEDI-CARE - CO-PAY DUE

City Tax ID.

Patient:
Run Number:
Incident Number:
E-Account:
Date of Service:

12/12/2015

Pick-up Location: Drop-off Location: Statement Date:

n: LONG BEACH MEMORIAL HOSPITAL e: 03/10/2016

Payment Due:

04/09/2016

Payment Options
Pay Online:

www.longbeach.gov (562) 570-7600, option 3

Pay by Phone: (562) 570-7600, Pay by Mail: P. O. Box 22600

Long Beach, CA 90801-5600

Billing Inquiries Call: (Email: /

(562) 570-7600 AmbulanceBilling@longbeach.gov

НСРС	Description	Quantity	Unit Price	Amount nit Price Due		Amount Paid/Adj
40427	BLS 2 Emergency Base Rate	1	\$1,675.00	\$1,675.00		
40425	BLS 2 Mileage	3.1	\$18.50	\$57.35		
40998	First Responder	1	\$250.00	\$250.00		
)4760	Pulse Oximeter	1	\$88.00	\$88.00		
23005	EKG 12LD	1	\$46.55	\$46.55		
	Medi/Medi Crossover	1			03/10/2016	-\$1,331.62
	Medi/Medi Crossover	1			03/10/2016	-\$34.81
	Payment - MediCare EFT	1			03/10/2016	-\$374.69
	Payment - MediCare EFT	1			03/10/2016	-\$17.67
	Mandated Contractual (CO253)	ated Contractual (CO253)			03/10/2016	-\$7.65
	Mandated Contractual (CO253)	1			03/10/2016	-\$0.36
	Payment - MediCare EFT	1			03/10/2016	-\$0.00
	Medi/Medi Crossover	1			03/10/2016	-\$100.10

Total Amount Due:

\$250.00

The City of Long Beach submitted a claim to Medi-Care and they have paid their portion of the claim. Please remit your co-pay amount. If you have any questions about this notice, please call (562) 570-7600.

	PLEASE DETACTION OF LONG BEACH CITY OF LONG BEACH EMERGENCY AMBULANCE SERVICE	Run Number:	AMERICA AMERICA - I ACCORDINATE
Make check payable to:	City of Long Beach P. O. Box 22600	Payment Due: Total Amount Due:	04/09/2016 \$250.0 0
	Long Beach, CA 90801-5600	Amount Enclosed: 8	

C'heck here if insurance information is provided on the back.



CITY OF LONG BEACH 333 West Ocean Blvd. Long Beach, CA 90802-4604 EMERGENCY AMBULANCE SERVICE

Patient: Run Number: Incident Number: E-Account: Date of Service: 12/12/2015 HCPC Description Quantity Medicare denied this claim on 03/03/16 for this reason: Non-covered charge(s). This change to be effective 4/1/2007: At least	DI-CARE - CO-PAY D					
Medicare denied this claim on 03/03/16 for this reason: Non-covered charge(s). This change to be effective 4-1/2007: At least	Pick-up Location: Drop-off Location: Statement Date: Payment Due:			LONG BEACH MEMORIAL HOSPITAL 03/10/2016		
Medicare denied this claim on 03/03/16 for this reason: Non-covered charge(s). This change to be effective 4/1/2007: At least	Payı P	ment Options Pay Online: Pay by Phone: Pay by Mail:	www.longbeach.gov (562) 570-7600, option P. O. Box 22600	•		
Medicare denied this claim on 03/03/16 for this reason: Non-covered charge(s). This change to be effective 4/1/2007: At least	Billing I	nquiries Call: Email:	Long Beach, CA 9080 (562) 570-7600 AmbulanceBilling a lo			
Non-covered charge(s). This change to be effective 4/1/2007: At least	Unit Price		Amount Paym Due D	ent Amoun ate Paid/Ad		
Code or NCPDP Reject Reason Code.)	one Remark Code must be pro	ovided (may be co	omprised of either the Remitt	ance Advice Remark		
		PRESA				
	Total Amount Due:	\$	250.00			
The City of Long Beach submitted a claim to Medi-Care and they have juestions about this notice, please call (562) 570-7600.	e paid their portion of the o	claim. Please r	emit your co-pay amount.	If you have any		
Cil	CHAND RETURN WHILLYOUR PAYME TY OF LONG BEACH NCY AMBULANCE SE		Run Number	:		
Make check payable to: City of Lor P. O. Box 2 Long Beac			Payment Due: Total Amount Due: Amount Enclosed: \$	04/09/2016 \$250.00		
	1					

Check here if insurance information is provided

on the back,



Declaration Supporting Waiver of Fees Owed Based on Hardship

Instructions: Please fill out this form stating all of the reasons that you are unable to pay the fees that you owe the City of Long Beach. Please provided as many details as possible explaining why you cannot pay the amount owed, such as job loss, medical condition, or the like. Please also indicate the amount that you can pay, if any. Please sign and date this declaration in the space provided. By signing this Declaration, you are also authorizing employees of the City of Long Beach to request and review your credit history from a credit reporting service.

١, إ	, Declare:
	(Your Name)
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*	
(Us	e Additional Pages if Necessary or Sign the Declaration)
l d ar	eclare under penalty of perjury under the laws of the State of California that the foregoing is true d correct, and that this declaration was executed on this day of, 20 in, California.
	(City)
	(Your Signature)
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