



**L.A. Care**  
HEALTH PLAN®

# Payment Acceptance - Receipt

## Receipt

**Date:** 08-31-2025

**Order Number:** 9084046993\_1756698642073

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### Billing Information

Mohammadnima Jafari  
18528 mayall st unit G  
northridge  
California  
91324  
United States of America

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### Payment Details

Card Type

Mastercard

Card Number

xxxxxxxxxxxx3937

Expiration Date

08-2030

Total amount

\$52.14

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Please keep a copy of this receipt for your records

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