COASTAL KIDS
A PEDIATRIC MEDICAL GROUP

PATIENT ACCOUNT: 107138

PATIENT NAME: BENNETT LARK

STATEMENT DATE	DUE DATE
02/01/2025	02/21/2025

Billing Phone: 949-599-2434

PAYMENT OPTIONS

You may pay your bill in full with a credit card, debit card or check.
Pay Online At: https://pay.balancecollect.com/m/coastalkids
Mail The Payment Using the Slip Below
Billing Phone: 949-599-2434
Office Hours: Mon-Friday 8:00-5:00

DATE	CODE	DESCRIPTION	CHARGE	INS RCPTS	PAT RCPTS	ADJUSTMENTS	PAT BALANCE
107138	BENNETT LARK						
10/07/2024	99212	Office visit, focused	$159.00	$10.12	$0.00	$103.88	$45.00
Payment		BC/BS OOA					
Adjustment		BC/BS OOA					
10/07/2024	86580	TB skin test	$34.00	$7.05	$0.00	$26.95	$0.00
Payment		BC/BS OOA					
Adjustment		BC/BS OOA					

0-30 Days	31-60 Days	61-90 Days	Over 90 Days
$0.00	$0.00	$0.00	$45.00

IMPORTANT MESSAGE

To avoid further collection action please remit payment.
Thank you for your prompt attention to your outstanding balance.
We are happy to answer any questions you may have.

AMOUNT DUE
$45.00

Please detach payment stub and return with payment

COASTAL KIDS
A PEDIATRIC MEDICAL GROUP
24422 Avenida De La Carlota
Suite 300
Laguna Hills, CA 92653-3618
RETURN SERVICE REQUESTED

Please Circle Method of Payment: VISA MasterCard DISCOVER AMERICAN EXPRESS

CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	NAME ON CARD	3 DIGIT CCV

DUE DATE	AMOUNT DUE	PATIENT ACCOUNT
02/21/2025	$45.00	107138

ADDRESSEE:

154288 - 328

ANDREW LARK
41 BAINBRIDGE AVE
LADERA RANCH CA 92694-0945

MAKE CHECKS PAYABLE/REMIT TO:

Coastal Kids Pediatric Med GRP
24422 AVENIDA DE LA CARLOTA STE 300
LAGUNA HILLS CA 92653-3628

0008 004288

154288-328-24429737

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