MAKE CHECKS PAYABLE TO:

SAN RAMON VALLEY FIRE PROTECTION DISTRICT
PO BOX 269110
SACRAMENTO CA 95826

FOR BILLING INQUIRIES CALL: 1(800) 906-6552
PST - 8:00am to 4:30pm

RUN NUMBER: 22-708202
INCIDENT NO: SRM220009855
DATE OF SERVICE: 11/12/2022

RUN NUMBER	STATEMENT DATE	DUE DATE	AMOUNT DUE
22-708202	01/30/2023	02/28/2023	2,043.95

AMOUNT PAID
$

ADDRESSEE:

WMN0130A 1300 1 MB 0.531
7000001338 00.0004.0227 1300/1

STEPHANIE K SCHLEGEL
6 ELIZABETH LN
DANVILLE CA 94526-1547

PLEASE REMIT TO:

SAN RAMON VALLEY FIRE PROTECTION DISTRICT
PO BOX 269110
SACRAMENTO CA 95826-9110

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT

SEE REVERSE SIDE FOR ADDITIONAL INFORMATION

INVOICE

RUN NUMBER: 22-708202
INCIDENT NO: SRM220009855

DATE OF SERVICE: 11/12/2022

DESCRIPTION	CHECK #	QUANTITY	COST PER UNIT	DATE	TOTAL CHARGE
Payment/Electronic Transfer	1TZ3874249			12/14/2022	-120.30
Payment/Electronic Transfer	1TZ3874249			12/14/2022	-735.75
Basic Emergency Ambulance Srvc		1	2,500.00		2,500.00
Mileage		10	40.00		400.00

PICK UP LOCATION
6 ELIZABETH LN, DANVILLE, CA 94526

DROPOFF LOCATION:
John Muir Medical Center-Walnut Creek

TOTAL AMOUNT DUE
2,043.95

Your insurance has incorreclty underpaid your claim. See reversed side on how to appeal for additional payment. As you may be ultimately responsible for the balance.

SAN RAMON VALLEY FIRE PROTECTION DISTRICT
PO BOX 269110
SACRAMENTO CA 95826-9110

PATIENT: STEPHANIE K SCHLEGEL

FOR BILLING INQUIRIES CALL TOLL FREE 1(800) 906-6552 PST - 8:00am to 4:30pm.
You may also submit insurance information at www.webillems.com/secure

PATIENT'S CHANGE OF MAILING ADDRESS

Address: _____

City: _____

State: _____ Zip: _____

New Phone #: ( ) _____

Social Security #: _____

PATIENT'S CHANGED INSURANCE INFORMATION

Insurance Co.: _____

Claim Office Address: _____

Policy #: _____ Group #: _____

Named of Insured: _____

Relationship of Patient to Insured: _____

Employer Name: _____

Employer Address: _____

Medicare #: _____

Authorization for release of Medical Information:

I authorize any holder of Medical information about me to release to Medicare, Medicaid and any insurance, as well as the provider of this service, any information or documentation in their possession needed to determine these benefits or the benefits payable for related services, whether in the past, now or in the future.

_____

Signature of Patient or Guardian