BASS MEDICAL GROUP

2637 Shadelands Dr
Walnut Creek, CA 94598

8573

Page 1 of 1

GUARANTOR NAME	ACCOUNT NUMBER	STATEMENT DATE	DUE DATE	AMOUNT DUE
NIKOLAI SCHLEGEL	331693	05/30/23	06/20/23	$18.01

INSURANCE COMPANY	GROUP/PLAN	POLICY/ID NUMBER	SUBSCRIBER NAME
UNITED HEALTHCARE PPO	700406	944254698	SCHLEGEL,NIKOLAI

Detail of Services, Charges, Claims, and Payments for: NIKOLAI SCHLEGEL

Service Date: 04/21/2023 **Patient Name:** NIKOLAI SCHLEGEL

Provider: MARWAHA, JATINDER **Location:** BASS TRI-VALLEY IM

Services and Charges

04/21/2023 **99214**	Office/Outpatient Established Mod Mdm	$460.00

Total Charges for this visit **$460.00**

Claims, Payments, Adjustments

ADJUSTMENTS

5/18/2023	Insurance Adjustment	$279.94

PAYMENTS

5/18/2023	Insurance Payment	$162.05

Subtotal Due for this visit: $18.01

Tue May 30 04:07:02 2023

This statement reflects the balance of your financial responsibility for your recent service(s). Please contact our office if you have any questions or concerns regarding your account at 925-627-3424. Thank you.
To pay online go to: www.bassmedicalgroup.com/pay-online/

acc1231_400-20230530040020-1a-522364978

Billing Inquiry
Call 925-627-3424 Monday - Thursday 8:00 am - 5:00 pm PST Friday 8:00 am - 3:00 pm PST

Pay Your Bill
Call 925-627-3424 Monday - Thursday 8:00 am - 5:00 pm PST Friday 8:00 am - 3:00 pm PST

f10033b

☐ Please check box if address is incorrect or insurance information has changed and indicate change(s) on reverse side.

BASS MEDICAL GROUP

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Walnut Creek, CA 94598

Please Make Checks Payable To:
BASS MEDICAL GROUP

To pay online go to: **www.bassmedicalgroup.com/pay-online/**

* ADDRESSEE

NIKOLAI SCHLEGEL
6 ELIZABETH LN
DANVILLE CA 94526-1547

Please detach and return this portion with payment.

Credit Cards Accepted

ACCOUNT NUMBER	STATEMENT DATE	DUE DATE
331693	05/30/23	06/20/23
AMOUNT NOW DUE	**AMOUNT ENCLOSED**	
$18.01	$	

For security purposes we are unable to accept credit card numbers by mail. Please call our office to make a credit card payment.

REMIT TO

BASS MEDICAL GROUP
PO BOX 97297
LAS VEGAS NV 89193-7297

00405100000000000003316930000000000018011

Do We Have Your Insurance Information?

Accurate insurance information helps ensure prompt payments by your insurance company. Complete this insurance information area only if information has not been previously provided or has changed. **Please enclose copies of the front and back of your insurance card.**

☐ Medicare ☐ Blue Cross ☐ Other Insurance ☐ Public Aid

Insured Name: _____ **Relation to Pt.:** _____ **Insurance Co. Name:** _____ **Co-Pay Amount:** _____

Insured Social Security #: _____ **Insurance Co. Address #:** _____

Group/Policy/Recipient #: _____ **Insurance Verification Phone #:** _____

Employer: _____ **Employer Address:** _____

I authorize to submit any or all medical data to my insurance company, and authorize the assignment of any benefits or payments. I understand I am financially responsible for charges not covered by this authorization.

Signed _____ Date _____

CHANGE OF ADDRESS

Name _____ **Phone** _____

Address _____

City _____ **State** _____ **Zip** _____