ADD. CORR. REQUESTED.

Pay This Amount	Payment Due By
17614907430	A
Refer to Above Pt. No. on All Inq.	U Q

06/25/90

For Information Regarding This Statement, Telephone ▶579-~~5060~~ 5730

ACCOUNTS OLDER THAN 90 DAYS ARE SENT TO A COLLECTION AGENCY
QUENTAS MAS DE 90 DIAS PASARA A UNA AGENCIA DE COLECCION.

Patient Name FRANZA ,GLADYS

212-000-0000

Send Payment To

LINCOLN MEDICAL CENTER
NYC HEALTH & HOSP CORP.
P.O. BOX 5491
G. P. O.
NEW YORK, NY 10087

Guarantor

17614907430
GLADYS FRANZA
225 EAST 106ST 1
NY,NY 10029

TO INSURE PROPER CREDIT TO YOUR ACCOUNT DETACH ALONG DOTTED LINE - AND RETURN TOP PORTION WITH YOUR PAYMENT.

APPLY AT HOSPITAL FOR MEDICAID ELIGIBILITY OR FEE REDUCTION INFORMATION CALL 579-5666 FOR AN APPOINTMENT UNLESS YOU CONTACT US IN 30 DAYS - YOUR ACCOUNT WILL BE TURNED OVER TO A COLLECTION AGENCY.

Patient Name FRANZA ,GLADYS

Last Stmt. 07/10/90 Prev. Bal. $ 175.00

TRANSACTION DATE	DESCRIPTION	AMOUNTS
06/25/90	ADULT ER PHYS 450	150.00

Hospital: LINCOLN MEDICAL CENTER LNO Stmt. Date 07/25/90

Patient No.: 17614907430

06/25/90 Adm. Date | Discharge Date | $ 325.00 Account Balance | $ .00 Est. Insurance Due* | $ 325.00 Pay This Amount

*Insurance is Estimated For Billing. Any Balance Unpaid Will Be Billed To The Patient.

Payments And Charges Received After The Date Of This Statement Will Be Reflected On The Next Statement.

Mr Michael Terrace

6/20 - sent to [illegible] / notes - will receive [illegible]