

P.O. Box 48954
Los Angeles, CA 90048-0954

Sample a Sample
123 Any Avenue
ANYTOWN, CA 90230

Pay Online: mymdlink.org
Pay by Phone: 866-803-1777
Written Correspondence:
LADMC Medical Center, P.O. Box 48954
Los Angeles, CA 90048-0954

GUARANTOR ACCOUNT INFORMATION

Guarantor Name: Sample A Sample
Guarantor Number: 18205

Summary	Billed/Pmts/Adjs	Outstanding Balance	Patient Balance
Payment Plan	\$16,147.12	\$16,147.12	\$300.29
New Activity Physician Service	\$225.85	\$225.85	\$225.85
New Activity Hospital Service	\$2,171.04	\$2,171.04	\$2,171.04
New Activity Hospital Service	\$18,544.01	\$18,544.01	\$2,697.18

Total Amount Due: \$2,697.18

Thank you for choosing LADMC for your healthcare needs. This statement explains the current status of accounts. Call us at 866-803-1777 if you have questions.

- If you have insurance coverage that is not reflected in this statement, contact us.
- Contractual discount we provide or payment mode are reflected in this statement.
- The balance remaining, listed in the Account Summary, is your responsibility and is due in the date on the date indicated. You may pay by cash, check and with most credit cards.
- We offer a variety of payment and programs for financial assistance based on need. Call us to how discuss how we can help

Customer Care Hours:

Monday-Friday, 8 am - 5pm (Closed for lunch from 12-1 pm)

- For automated account information, questions or to discuss a possible payment plan or financial assistance based on need, call 866-803-1777.
- Contact us by email: patient.billing@cshs.org

Please note, there may be additional charges that have not yet been posted.

You Account Detail is on the following pages.

Statement Date June 09, 2023
Guarantor Number 18205

Check here if your address or insurance information has changed. Please indicate changes on the back of this page.

LADMC Medical Center
1711 West Temple Street
Los Angeles, California 90026

Guarantor Name Due Date
Sample A Sample June 29, 2023

Amount Now Due	Amount I Am Paying
\$2,697.18	\$

Select One: ☐ Payment Enclosed ☐ Charge



Card: _____

Exp. Date _____

Print Cardholder Name _____

Signature _____

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