COMPREHENSIVE CANCER CENTERS

CCCN
PO BOX 600
OAKS PA 19456

Clinic Statement

Questions? Call us at 702-952-3350

Payment Line

Easy, automated phone payments at your convenience.

Call 24/7: Coming Soon

Account Number	Due By	Amount Due	Amount Paid
[redacted]	Upon Receipt	$115.57	$

Addressee

[redacted]

Please make checks payable and remit to:

CCCN
PO BOX 911265
DALLAS TX 75391-1265

Please detach and return top portion with payment.

Account Number	Account Name	Statement Date	Payment Due By
[redacted]	[redacted]	08/07/2024	Upon Receipt

Date	Service Description	Charges	Payments/ Adjustments	Patient Balance
	Patient: [redacted] *Provider: WOLFRAM SAMLOWSKI MD Loc: CCCN SOUTHERN HILLS*			
04/18/2024	THER/PROPH/DIAG INJ, IV PUSH	$240.00		
04/18/2024	INJECTION, ZOLEDRONIC ACID,1 MG	$2,310.00		
05/15/2024	DUAL COVERAGE EPO ADJUSTMENT		-$122.25	
07/08/2024	DUAL COVERAGE EPO ADJUSTMENT		$122.25	
07/08/2024	DUAL COVERAGE EPO PAYMENT		-$212.27	
07/08/2024	DUAL COVERAGE EPO ADJUSTMENT		-$2,011.60	
07/08/2024	DUAL COVERAGE EPO PAYMENT		-$88.31	
07/08/2024	DUAL COVERAGE EPO ADJUSTMENT		-$122.25	
	Patient Amount			$115.57
	Total Account Balance	**$2,550.00**	**-$2,434.43**	**$115.57**
	Thank you for choosing our organization for your healthcare needs. Please pay the amount shown above.			

MOBILE QUICK PAY

Scan me!

Make a quick and easy payment online with your smartphone

cccnevada.com/patient-resources/pay-bill/

Statement Summary

Total Charges: $2,550.00
Insurance Payments/Adjustments: .....-$2,434.43
Patient Payments/Adjustments: $0.00

AMOUNT DUE: $115.57

Change of Address

Name (Last, First, Middle Initial)		
Address		
City	**State**	**ZIP**
Telephone		

Primary Insurance Updates

Primary Insured Name			
Primary Insurance Name		**Effective Date**	
Primary Insurance Street Address			
City	**State**	**ZIP**	**Telephone**
Employer Name		**Group Number**	
Subscriber ID #		**Policyholder's Date of Birth**	

Secondary Insurance Updates

Secondary Insured Name			
Secondary Insurance Name		**Effective Date**	
Secondary Insurance Street Address			
City	**State**	**ZIP**	**Telephone**
Employer Name		**Group Number**	
Subscriber ID #		**Policyholder's Date of Birth**	

Explanation of Statement

This statement is the summary on the unpaid balance of your account which is now your responsibility. Charges reflect only services rendered by US Oncology and its affiliates.

Contact Us

This billing statement represents only services rendered with current patient liability. If you have any questions, please call the Customer Service Department at the number on the front of your statement during normal business hours.

Financial Policy

Payment is due in full upon receipt of your first statement. If you are unable to pay in full, US Oncology's staff will work with you to establish an acceptable payment plan. Partial payments made toward your balance will not stop our collection process unless you have made payment arrangements with us. Please contact our Financial Services staff at number provided on the front of your statement; our Financial Advisors will be happy to assist you with the payment option that best addresses your needs.

Associated Expenses

You may also receive medical bills from other providers of services related to your US Oncology visit. It is expected that you will work directly with these providers regarding their charges.