Name

Street address

City, CA ______

____________________ Thank you for your business.

Your insurance carrier has processed claims for services provided to your dependents and determined $_________________ as your responsibility.

Please review the attached insurance Explanation of Benefits (EOB's) and submit payment to American Indian Health & Services. A return envelope has been provided to you with this letter.

If you have any questions, you may contact ______________________at____________.

Date of service	Amount you are to pay
04/22/09	$ _______________________
08/14/09	$ _______________________
Total Due:	$ _______________________