

**BCCCP**  
Breast and Cervical  
Cancer Control Program  
**BCCCP**  
PO Box 1511  
FLINT, MI 48501-1511



**CHECK STOCK**

200708070165

**TEST**

**Forwarding Service Requested**

SINGLE PIECE

1 0.3840 SP 0.410

MCLAREN REGIONAL MED CTR-LABORA 1  
1001 WALLI STRASSE  
STE F  
BURTON, MI 48509

**Questions Call us at 888-327-0671**

**Group Name:** MDCH - BCCCP  
**Group No.:** BCCCP  
**Division:** 1  
**Provider TIN:** 382383119  
**Internal ID:** 1019913  
**Check #:** 3  
**Check Date:** 08/03/2007

**PROVIDER PAYMENT REPORT**

| No.                     | Date(s) Of Service | Proc Code | Description Of Service | Total Charges | Provider Discount | Ineligible Amount | Ineligible Code    | Deductible | Co-Pay/Co-Ins | Other Carrier | Benefits Paid |
|-------------------------|--------------------|-----------|------------------------|---------------|-------------------|-------------------|--------------------|------------|---------------|---------------|---------------|
| Claim#:074227720        |                    |           | Insured Name JOHN TEST |               |                   |                   | Insured ID 1061664 |            |               |               |               |
| Patient Acct#: 1061664  |                    |           | Patient Name JOHN TEST |               |                   |                   |                    |            |               |               |               |
| 01                      | 07/01-07/01/2007   | 99213     |                        | 100.00        | 0.00              | 0.00              |                    | 0.00       | 0.00          | 0.00          | 100.00        |
| <b>Claim Sub-Totals</b> |                    |           |                        | 100.00        | 0.00              | 0.00              |                    | 0.00       | 0.00          | 0.00          | 100.00        |

**Payment To:** MCLAREN REGIONAL MED CTR-L  
**Check Date:** 08/03/2007  
**Check No.:** 3  
**Amount:** 100.00

| Total Charges           | Provider Discount | Ineligible Amount | Deductible | Co-Pay/Co-Ins | Other Carrier | Benefits Paid |
|-------------------------|-------------------|-------------------|------------|---------------|---------------|---------------|
| <b>Statement Totals</b> | 100.00            | 0.00              | 0.00       | 0.00          | 0.00          | 100.00        |

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PAY \*\*\*One Hundred Dollars\*\*\*

TO THE ORDER OF MCLAREN REGIONAL MED CTR-LABORATORY

9-32/720  
CHASE

**VOID**

**Check No.**  
3  
**Check Date:** 08/03/2007  
Void if after 90 days  
**PAY THIS AMOUNT**  
\*\*\*\$100.00

*Kathy Kendall*

Authorized Signature