C:\Temp\reflect
reflect_01.txt

3/4/24

Devoted Health
Member Reimbursements
Box 211037
Eagan, MN 55121

re: Doctor

I visited my reflect doctor on 02/06/24 and paid $112.50 with my credit card. On 02/08/24, I submitted the invoice for reimbursement.

The doctors office thought it over and decided they wanted to bill me an additional $52.50. I wrote them a check and paid that bill by mail.

I called Devoted on 03/04/24 to check on my reimbursement. I was told that Devoted could find no record of ever receiving my reimbursement form, as if it had been lost in the mail. I am now submitting another reimburse ment form, this time with both the $112.50 and the $52.50, for a total of $165.00.

Philip Rice
11268 E Linvale Dr
Aurora, CO 80014

D5SYZR
dob = 04/25/1953

Reimbursement form
Get paid back for covered care

PROVIDE YOUR PERSONAL INFORMATION

First and last name: Philip Rice

Birth date (mm/dd/yyyy): 04 25 1953

Member ID number: D5SYZR

TELL US ABOUT WHAT YOU PAID FOR

Service or item: Doctor

Date when you paid: 3/2/24 (check Date)

How much you paid: 52.50

Type of purchase: ☒ Covered healthcare ☐ Dental care ☐ Eyewear ☐ Wellness Bucks

☐ Other

Service or item:

Date when you paid:

How much you paid:

Type of purchase: ☐ Covered healthcare ☐ Dental care ☐ Eyewear ☐ Wellness Bucks

☐ Other

Service or item:

Date when you paid:

How much you paid:

Type of purchase: ☐ Covered healthcare ☐ Dental care ☐ Eyewear ☐ Wellness Bucks

☐ Other

SIGN THE FORM

Your signature: Philip Rice

Today's date (mm/dd/yyyy): 3.4.24

Don't forget to attach your supporting documents! See next page for details.

REFLECT HEALTH
MATTHEW DHIEUX, PA

Patient: **Philip G Rice**
ID# 1066478A9821
Statement Date: **2/24/24**

018284 1/1

Hi Philip, your balance of $52.50 is due.

Payment due upon receipt of statement.

Note From Your Practice

Summary

You have been billed for 1 service. This balance is your responsibility.

Original Cost:	$220.00
Your payments and credits:	-$167.50
Amount due:	$52.50

Details on back >

Questions? Call us at **303-584-5844**
Reference your ID: **1066478A9821**

Pay Online

In partnership with athenahealth

Go to payment.athenahealth.com
Enter your code: HQGB-3JRT-2BC-1CXD

View bill breakdown, see past payments, and print itemized receipts.

or

Scan this code for quick access
Don't want to type your code? No problem. Scan this code with your phone to access your bills.

Prefer to pay by check? Detach the slip below and include your payment. **No cash, stapled checks, or other paper.** Thank you!

REFLECT HEALTH
PO BOX 14099
BELFAST, ME 04915

Make checks payable to: REFLECT HEALTH
1. Fill out the amount enclosed below.
2. Place in provided envelope and mail.

Patient Account #	Amount Enclosed
1066478A9821	

AB 01 018284 84888 H 60 A
PHILIP G RICE
11268 E LINVALE DR
AURORA CO 80014-3071

REFLECT HEALTH
ATTN # 32313Y
PO BOX 14000
BELFAST ME 04915-4033

Reimbursement form
Get paid back for covered care

PROVIDE YOUR PERSONAL INFORMATION

First and last name:

Philip Rice

Birth date (mm/dd/yyyy):

04 25 1953

Member ID number:

D5SYZR

TELL US ABOUT WHAT YOU PAID FOR

Service or item:

Doctor

Date when you paid:

02 06 2024

How much you paid:

112.50

Type of purchase: ☒ Covered healthcare ☐ Dental care ☐ Eyewear ☐ Wellness Bucks

☐ Other_____

Service or item:

Doctor

Date when you paid:

02 06 2024

How much you paid:

Type of purchase: ☐ Covered healthcare ☐ Dental care ☐ Eyewear ☐ Wellness Bucks

☐ Other_____

Service or item:

Date when you paid:

How much you paid:

Type of purchase: ☐ Covered healthcare ☐ Dental care ☐ Eyewear ☐ Wellness Bucks

☐ Other_____

SIGN THE FORM

Your signature:

Philip Rice

Today's date (mm/dd/yyyy):

02 08 2024

Don't forget to attach your supporting documents! See next page for details.

Reflect Health

7720 S Broadway
Suite 310
LITTLETON, CO, 80122-2624
(303) 584-5844

Approval code:	006310	Transaction type:	PURCHASE
Record number:	982562	Date/time:	02/06/2024 01:57 PM MST
Trace number:	308053	Type:	Visa
Transaction reference number:	206205716 CHIP	Account number:	XXXXXXXXXXXX1189
Transaction identifier:	304037754362067	Cardholder name:	PHILIP G RICE
Application Label:	Visa Credit	Patient identifier:	1066478
TC:	A5A0E7BA2F5A6B20		
TVR:	0080008000		
AID:	A0000000031010		

Subtotal: 112.50
Sales Tax: 0.00

Total: 112.50

(customer copy)

REFLECT HEALTH, LLC

please send payments to:
REFLECT HEALTH, LLC
PO BOX 32313
BELFAST, ME 04915-0210
billing phone: (303) 357-2559

department of service:
Reflect Health
7720 S BROADWAY
LITTLETON, CO 80122-2624
dept phone: (303) 584-5844

printed
02/06/2024 01:57 PM

GUARANTOR NAME AND ADDRESS	PATIENT #	PATIENT NAME	PROVIDER	DATE	DEPARTMENT
PHILIP G RICE 11268 E LINVALE DR AURORA, CO 80014	1066478	PHILIP G RICE	MATTHEW DHIEUX, PA	02/06/2024	Reflect Health

DOB.	TELEPHONE	CURRENT INSURANCE	CERTIFICATE#	AUTH#
04/25/1953	(214) 666-4321	*SELF PAY*		

PAYMENTS ON 02/06/2024

Post Date	Date of Service	Diagnosis Codes	Procedure Code	Original Insurance Plan	Supervising Provider	Reason For Payment	Method of Payment	Amount
02/06/2024				*SELF PAY* [0]		Payment for Todays Service	MC/VISA **********1189	**$112.50**

Total Payment Amount **$112.50**