



Meadow Brook

ANTRIM COUNTY
MEDICAL CARE FACILITY

Date: _____

To: _____

RE: _____

Meadow Brook will bill your _____ (Part A) Co-Insurance claims. We will ask your insurance company to send the payment to the resident/guardian/sponsor.

Meadow Brook will bill you the (Part A) Co-Insurance rate of \$ _____ per day. Payment is due by the 10th working day of each month.

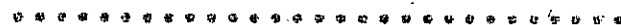
(resident/guardian/sponsor)

(Date)

(witnessed by)

(Date)

Co-insurance/kw (231) 533-8661 • FAX (231) 533-6028 • e-mail: meadowbrook@torchlake.com



4543 South M-88 Highway • Bellaire, MI 49615-9552