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