Billing Inquiry

Haydee Docasar, M.D.
6785 W Russell Road, Suite 130
Las Vegas, NV 89118
info@HaydeeDocasarMD.com
702-550-4870 p
1-855-898-8685 f

Date:_____

Patient name: _____

DOB: _____

Date of service in question: _____

Insurance information:

Insurance Name: _____

Member ID_____

Claims P.O. Box_____

Billing Issue:

_____

_____

_____

_____

_____

After receipt of this form we will get back to you no later than **7-14** business days.

Haydee Docasar, M.D.

www.haydeedocasarmd.com

Credit Card Payment by Phone

Date: _____ Patient Name: _____

VISA / MASTERCARD
(Circle One)

_____
Name of Cardholder

_____
Credit Card Number

_____
Expiration Date Security Code
(3 digit code on signature line of the card)

_____
Address ZIP Email

$_____
Amount Paid By Patient

_____
Signature of Cardholder (if available)

** Once all information is filled out and signed, please fax back to **(855-898-8685)** or email to **drdocasar@gmail.com**

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Email: Info@haydeedocasarmd.com