

Major Medical Program

Your name and address	
Your email address	
Person with spina bifida	
What was the reason for the surgery or hospital bill?	
Date of hospitalization or surgery	
Total cost	
Current unpaid balance	
Did you request money from another source? If "yes," please explain	
Your signature and date	

Please attach:

1. A copy of the bill showing the initial cost and date of service.
2. Also attach the most recent bill that shows your current unpaid balance.
3. We will pay the hospital, physician or collection agency directly. Please provide a bill-payment stub and the envelope they provided so that we can send the payment to the correct location and the correct account.