



18th Medical Group Medical Services Accounts Payments

All questions must be answered, except those marked 'Optional'.

Sponsor First Name:

Sponsor Last Name:

Patient Name (optional):

Sponsor SSN (Last 4):

Mailing Address:

City/APO/FPO:

State:

Zip Code:

Account Number(s):

Amount(s):

Total Payment:

Payment Method: Electronic checking/savings debit Credit Card