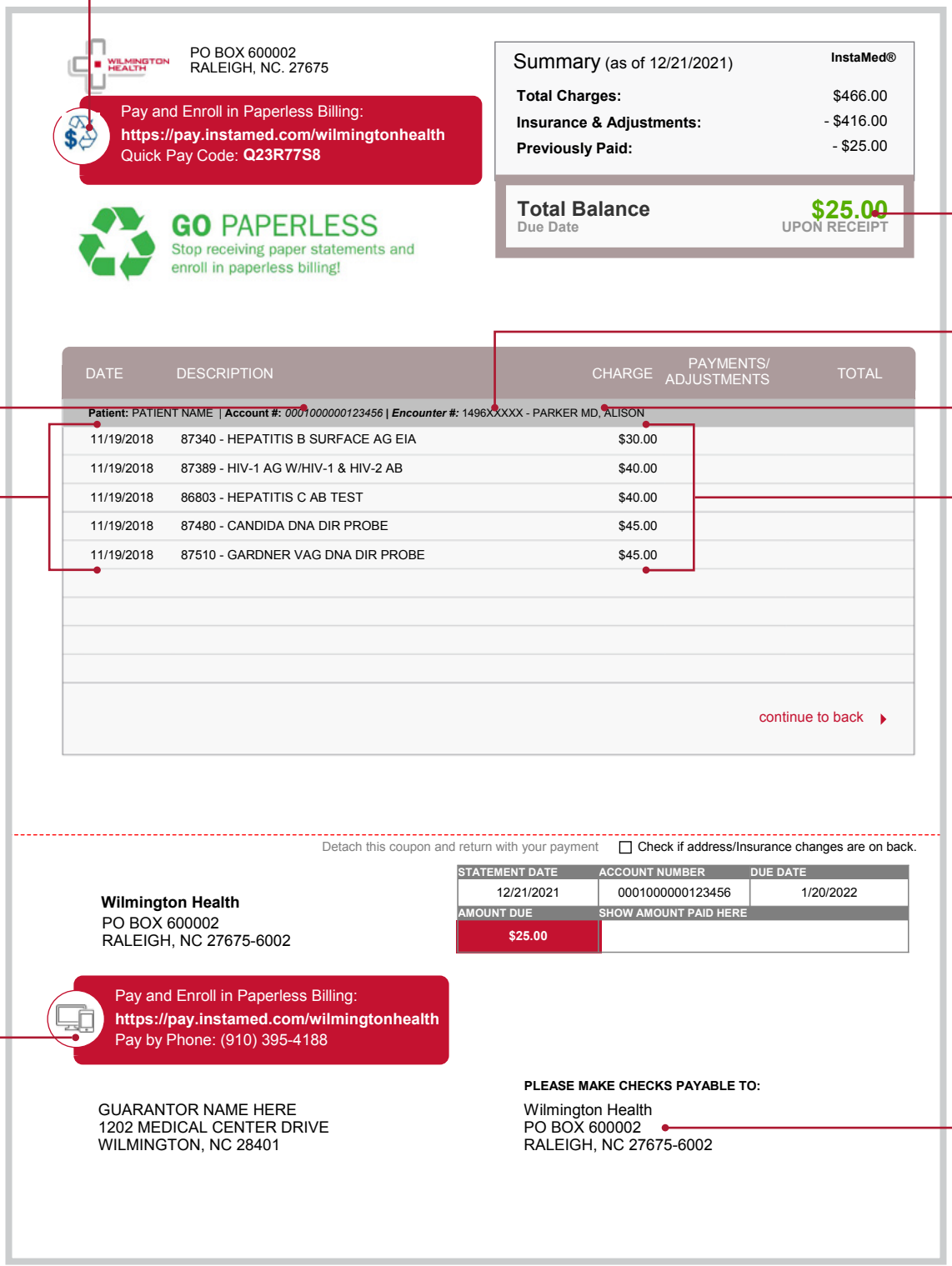
1 Pay online, create an account, set up a payment plan and enroll in e-statements.



PO BOX 600002
RALEIGH, NC. 27675

Pay and Enroll in Paperless Billing:
https://pay.instamed.com/wilmingtonhealth
Quick Pay Code: **Q23R77S8**

GO PAPERLESS
Stop receiving paper statements and enroll in paperless billing!

Summary (as of 12/21/2021) — **InstaMed®**

Total Charges:	$466.00
Insurance & Adjustments:	- $416.00
Previously Paid:	- $25.00

Total Balance — **$25.00**
Due Date — UPON RECEIPT

2 Total Patient Balance

5 Encounter Number

Account Number 4

6 Rendering Provider

Service Date 3

7 Outstanding Charges

DATE	DESCRIPTION	CHARGE	PAYMENTS/ ADJUSTMENTS	TOTAL
Patient: PATIENT NAME | **Account #:** *0001000000123456* | ***Encounter #:*** 1496XXXXX - PARKER MD, ALISON				
11/19/2018	87340 - HEPATITIS B SURFACE AG EIA	$30.00		
11/19/2018	87389 - HIV-1 AG W/HIV-1 & HIV-2 AB	$40.00		
11/19/2018	86803 - HEPATITIS C AB TEST	$40.00		
11/19/2018	87480 - CANDIDA DNA DIR PROBE	$45.00		
11/19/2018	87510 - GARDNER VAG DNA DIR PROBE	$45.00		

continue to back

Detach this coupon and return with your payment ☐ Check if address/Insurance changes are on back.

STATEMENT DATE	ACCOUNT NUMBER	DUE DATE
12/21/2021	0001000000123456	1/20/2022
AMOUNT DUE	**SHOW AMOUNT PAID HERE**	
$25.00		

Wilmington Health
PO BOX 600002
RALEIGH, NC 27675-6002

Pay and Enroll in Paperless Billing:
https://pay.instamed.com/wilmingtonhealth
Pay by Phone: (910) 395-4188

Customer Service Number 8

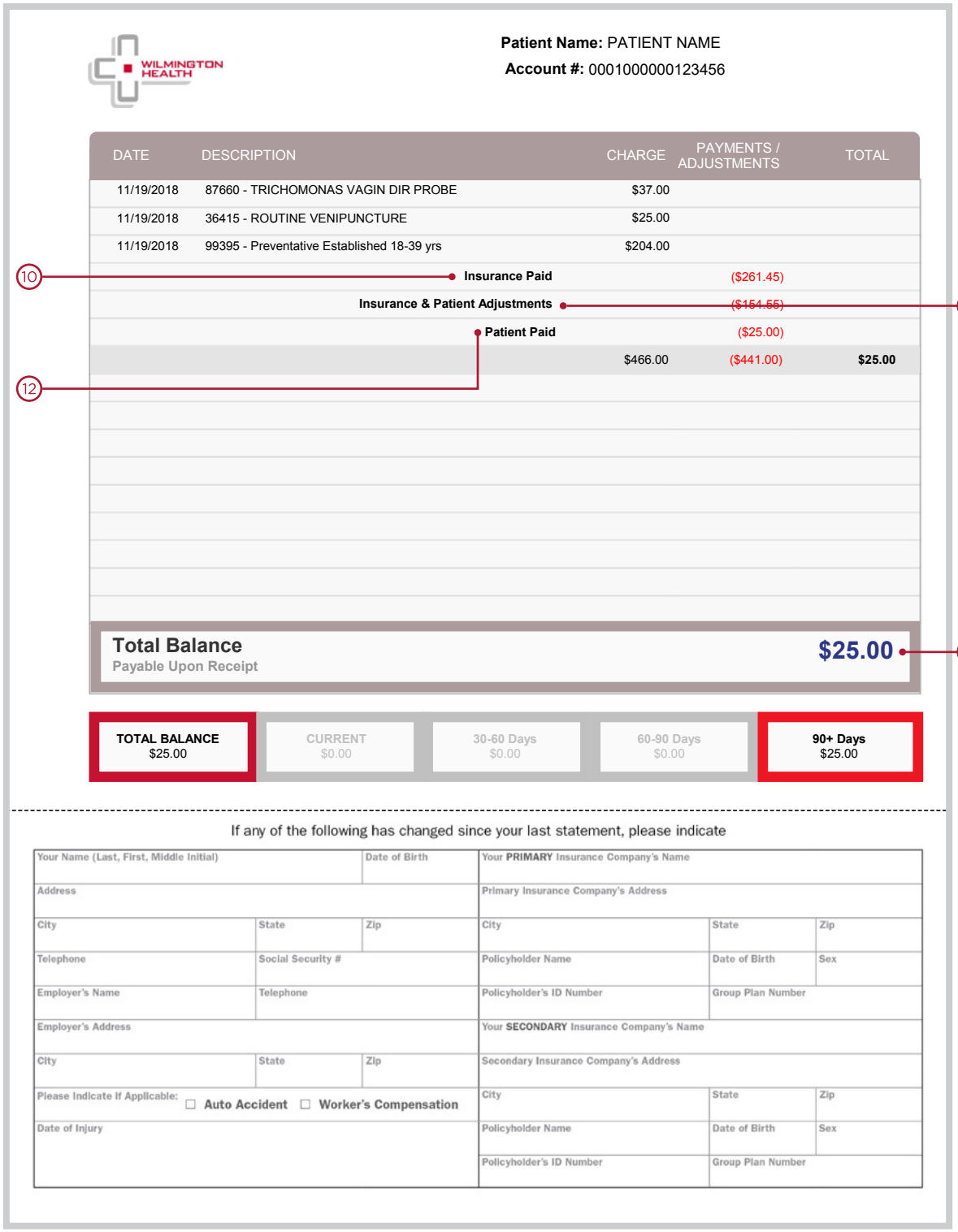
GUARANTOR NAME HERE
1202 MEDICAL CENTER DRIVE
WILMINGTON, NC 28401

PLEASE MAKE CHECKS PAYABLE TO:
Wilmington Health
PO BOX 600002
RALEIGH, NC 27675-6002

9 Payment Address

WILMINGTON HEALTH

WILMINGTONHEALTH.COM



Patient Name: PATIENT NAME
Account #: 0001000000123456

DATE	DESCRIPTION	CHARGE	PAYMENTS / ADJUSTMENTS	TOTAL
11/19/2018	87660 - TRICHOMONAS VAGIN DIR PROBE	$37.00		
11/19/2018	36415 - ROUTINE VENIPUNCTURE	$25.00		
11/19/2018	99395 - Preventative Established 18-39 yrs	$204.00		
	Insurance Paid		($261.45)	
	Insurance & Patient Adjustments		~~($154.55)~~	
	Patient Paid		($25.00)	
		$466.00	($441.00)	**$25.00**

Total Balance
Payable Upon Receipt **$25.00**

TOTAL BALANCE	CURRENT	30-60 Days	60-90 Days	90+ Days
$25.00	$0.00	$0.00	$0.00	$25.00

If any of the following has changed since your last statement, please indicate

Your Name (Last, First, Middle Initial)		Date of Birth	Your **PRIMARY** Insurance Company's Name		
Address			Primary Insurance Company's Address		
City	State	Zip	City	State	Zip
Telephone	Social Security #		Policyholder Name	Date of Birth	Sex
Employer's Name	Telephone		Policyholder's ID Number	Group Plan Number	
Employer's Address			Your **SECONDARY** Insurance Company's Name		
City	State	Zip	Secondary Insurance Company's Address		
Please Indicate If Applicable: ☐ Auto Accident ☐ Worker's Compensation			City	State	Zip
Date of Injury			Policyholder Name	Date of Birth	Sex
			Policyholder's ID Number	Group Plan Number	

10 Total Insurance Payments

12 Total Patient Payments

11 Total Insurance and Patient Adjustments

13 Total Patient Balance

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