

1 Pague en línea, cree una cuenta, configure un plan de pago e insírbase en estados de cuenta electrónicos.



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 Saldo de pago total

4 Número de cuenta

3 Fecha de servicio

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 ▶				

5 Número de encuentro

6 Proveedor de renderizado

7 Cargos pendientes

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

**Wilmington Health**  
PO BOX 600002  
RALEIGH, NC 27675-6002

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



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

8 Número de teléfono del servicio de atención al cliente

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 Dirección de Pago





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		(\$164.55)	
	Patient Paid		(\$25.00)	
		\$466.00	(\$441.00)	\$25.00
<b>Total Balance</b> Payable Upon Receipt				<b>\$25.00</b>

Pagos totales del seguro

Pagos totales del paciente

Seguros totales y ajustes del paciente

Saldo total del paciente

<b>TOTAL BALANCE</b> \$25.00	CURRENT \$0.00	30-60 Days \$0.00	60-90 Days \$0.00	<b>90+ Days</b> \$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: <input type="checkbox"/> Auto Accident <input type="checkbox"/> Worker's Compensation						City		State	Zip
Date of Injury						Policyholder Name		Date of Birth	Sex
						Policyholder's ID Number		Group Plan Number	

