



### Payment Address



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		(\$164.55)	
	Patient Paid		(\$25.00)	
		\$466.00	(\$441.00)	\$25.00
Total Balance				\$25.00
Payable Upon Receipt				

Total Insurance Payments

Total Patient Payments

Total Insurance and Patient Adjustments

Total Patient Balance

TOTAL BALANCE  
\$25.00

CURRENT  
\$0.00

30-60 Days  
\$0.00

60-90 Days  
\$0.00

90+ Days  
\$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			

