MAKE CHECKS PAYABLE TO:

PROVIDER/CLINIC NAME
PO BOX 180680
DELAFIELD, WI 53018-0680

IF PAYING BY CREDIT CARD, FILL OUT BELOW:
CHECK CARD USING FOR PAYMENT

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS

CARD NUMBER

AUTHORIZATION CODE: _ _ _ _
(usually last 3 or 4 digits on back of card in signature line)

SIGNATURE

EXP. DATE

STATEMENT DATE	PAY THIS AMOUNT	ACCT. #
06/01/2019	$212.89	53126

DUE DATE
DUE UPON RECEIPT

SHOW AMOUNT PAID HERE $

RETURN SERVICE REQUESTED 8 2

JOHN/JANE DOE
ADDRESS
CITY, STATE ZIP

29691
29691
06223668

MAKE CHECKS PAYABLE / REMIT TO:

PROVIDER/CLINIC NAME
PO BOX 180680
DELAFIELD, WI 53018-0680

☐ Please mark box and indicate any change in address on reverse side.

STATEMENT

Detach at perforation and return above portion with payment.