

MAKE CHECKS PAYABLE TO:

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



RETURN SERVICE REQUESTED 8 2



JOHN/JANE DOE
ADDRESS
CITY, STATE ZIP



8962390
1981
2861
0623988

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

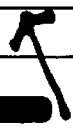
VISA MASTERCARD DISCOVER AMERICAN EXPRESS

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 \$ _____



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

STATEMENT

Detach at perforation and return above portion with payment.