

# Sample Statement

View billing name (highlighted in red) to select correct payment area.

**Nemours.** Children's Health System

PO Box 740198  
Atlanta GA 30374-0198



005386 0101

RETURN SERVICE REQUESTED

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.		
CHECK CARD USING FOR PAYMENT		
<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> VISA
CARD NUMBER		AMOUNT
SIGNATURE		EXP. DATE
STATEMENT DATE 04/26/14	PAY THIS AMOUNT 20.00	ACCT.# 12345678
PAYMENT DUE DATE 05/13/14	SHOW AMOUNT PAID HERE \$	

ADDRESSEE: REMIT TO: 608865 (PC1)

JOHN Q. PATIENT  
123 N. MAIN STREET  
ANYTOWN, USA 12345-6789

ALFRED I DUPONT HOSPITAL  
PO BOX 740198  
ATLANTA GA 30374-0198



0009800056789000123450000 0001

Please check box if above address is incorrect or insurance information

STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

Patient  
Hospit  
Hospit  
Hospit  
Discha

ALFRED I DUPONT HOSPITAL  
PO BOX 740198  
ATLANTA, GA 30374-0198

Revenue Code	Description	Quantity	Charge Amount
0300	Laboratory Pathological	4	\$1,035.00
0360	Operating Romm Services	1	\$3,001.00
0320	Radiology	2	\$6,034.00

Charges	Patient Payment	OR ONE OF THE FOLLOWING:	Patient Balance
\$5,865.00	\$0.00	\$5,865.00	\$5.00

Patient  
Hospit  
Hospit  
Hospit  
Discha

NEMOURS CHILDREN'S HOSPITAL  
PO BOX 105534  
ATLANTA, GA 30348-5534

Reven

0360	Operating Romm Services	1	\$3,001.00
0320	Radiology	2	\$634.00

NEMOURS CHILDREN'S SPECIALTY CARE  
PO BOX 530253  
ATLANTA, GA 30353-0253

\$85.00