P.O.BOX 4912
TRENTON NJ 08650-4912

Statement Date

Test Account
123 Test Street
Stoughton, WI 53589

8119-1

Questions

Billing questions or changes in insurance coverage?

Toll Free: 800-616-3443
Fax: 800-742-7789

Qualink on behalf of Stoughton Hospital

First Request For Payment

Account Activity

Name	Account #	Service	Charges	Payments	Adjustments	Balance
ACCOUNT	12345678	Date of service	$$.$$	$$.$$	$$.$$	$$.$$

Account Number

Balance Due From Patient: $$.$$

Please see reverse side for Important Information

Important Message

Thank you for choosing STOUGHTON HOSPITAL for your health care needs. We value your use of our services and facility. Our records indicate that the remaining balance is now your responsibility. If you have questions regarding amounts paid by your insurance company, please contact them directly.

When mailing your payment, for your convenience, we accept payment by check, credit card or money order. If you choose to pay by credit card, please complete the appropriate information at the bottom of this letter. Financial transactions can also be made by telephone by calling our Customer Service Representatives. If you have made this payment within five (5) days of the above date, please disregard this request. Your prompt payment is appreciated. Should you be unable to remit payment in full, please contact our Customer Service Representatives for alternate payment arrangements.

Please Return Lower Portion With Your Payment In The Enclosed Envelope

IF PAYING BY CREDIT CARD COMPLETE BELOW

CARDHOLDER'S NUMBER	EXP DATE	AMOUNT
CARDHOLDER'S NAME		
CARDHOLDER ADDRESS	ZIP CODE	
CARDHOLDER SIGNATURE		

Name	Account #	Service	Balance
ACCOUNT	12345678	Date of service	$$.$$

Account Number

Balance Due: $$.$$

Remit This Payment Stub To:
STOUGHTON HOSPITAL
P.O.BOX 78216
MILWAUKEE WI 53278-8216

Test Account
123 Test Street
Stoughton, WI 53589