

Sample Statement



STATEMENT OF HOSPITAL/PHYSICIAN SERVICES

Guarantor # **10682**
 Responsible Party **Dunning Echpat**
 Statement # 17823
 Statement Date 09/25/22

Account Balance
\$8,293.56

Minimum due by 10/23/22
\$8,293.56

Questions?

- Call (844) 457-6198 or (570) 768-3000 Billing Customer service representatives are available 7:30 AM to 5:30 PM EST
- Pay online <http://www.evanhospital.com/mychart>
- Use activation code **3VX7K-M5DPJ**
- Not interested in signing up for MyChart? Use the information below to pay as a guest.
- Guest Information **Guarantor #:** 10682 **Name:** ECHPAT,DUNNING

Federal guidelines prohibit us from disclosing any account information if you are not the patient or authorized representative. In order to discuss such information, the patient or authorized representative must provide consent.

Detach and return bottom portion with payment. Make checks payable to Evangelical Community Hospital and write your guarantor # on the check.



One Hospital Drive
 Lewisburg, PA 17837-9350

My address or insurance information has changed.
 Changes are written on the back of this form.

Due Date:	Guarantor #	Statement Date
10/23/22	10682	09/25/22
Amount Due	Card #	
\$8,293.56		
Amt Enclosed	Exp Date	CVV (3-digit code on back)
	Signature	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DUNNING ECHPAT
 67 FRONT ST
 WILBURTON PA 17888

EVANGELICAL COMMUNITY HOSPITAL
 PO BOX 4885
 LANCASTER PA 17604-4885

SAMPLE