MEDICAL STATEMENT

Statement No.	
Date	
Patient ID	

PATIENT INFORMATION

Name:

Address:

Phone:

DOB:

INSURANCE INFORMATION

Provider:

Policy No:

Group No:

Insured Name:

DATE	CPT/HCPCS	DESCRIPTION OF SERVICE	QTY	UNIT COST	TOTAL

Total Charges	
Insurance Paid	
Adjustments	
Balance Due	

Authorized Representative Signature

Patient/Responsible Party Signature