

# Healthcare Provider Billing Statement

Provider Name

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Provider Address

Provider Phone

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Patient Name

Patient ID

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Statement Date

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Account #

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Date of Birth

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Insurance

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## Services & Charges

Date of Service	Description	Procedure Code	Charge	Adjustments	Insurance Payment	Patient Payment	Amount Due

Total Charges:

Total Adjustments:

Total Payments:

**Amount Due:**

## Notes / Instructions

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Payment Received Date

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Received By

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