Medical Billing Statement

Patient Name

_____

Statement Date

_____

Patient ID / Account Number

_____

Date of Birth

_____

Provider Name

_____

Provider Phone

_____

Patient Address

_____

Insurance Information

_____

Service Details

Date of Service	Procedure / Description	CPT / Code	Charges	Payments	Adjustments	Balance

Total Charges

_____

Total Payments / Credits

_____

Total Adjustments

_____

Amount Due

_____

Comments / Notes

_____

Patient / Responsible Party Signature

Date