Medical Billing Statement

Date Issued: _____
Statement #: _____

Patient Name: _____	**Patient ID:** _____
Date of Birth: _____	**Phone:** _____

Provider Name: _____	**Provider NPI:** _____
Provider Address: _____	**Provider Phone:** _____

Date of Service	Procedure/Code	Description	Charge	Insurance Payment	Patient Payment	Balance Due
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
		Total	_____	_____	_____	_____

Notes / Additional Information:

Thank you for choosing our medical services.