Medical Expense Statement

Date: _____
Statement #: _____

Patient Name

_____

Date of Birth

_____

Provider Name

_____

Provider Address

_____

Insurance Policy #

_____

Contact Number

_____

Date of Service	Description of Service	Provider	Amount Billed	Insurance Paid	Patient Owes
__/__/____	_____	_____	_____	_____	_____
__/__/____	_____	_____	_____	_____	_____
__/__/____	_____	_____	_____	_____	_____

Total Amount Billed: _____

Total Insurance Paid:_____

Total Patient Owes: _____

Patient Signature

Provider Signature