Itemized Billing Statement for Insurance Processing

Patient Name: _____

Patient ID: _____

Date of Birth: _____

Statement Date: _____

Billing Number: _____

Insurance: _____

Provider Name: _____

Provider Address:

_____

Phone: _____

Date	Service / Procedure	CPT/HCPCS	Qty	Unit Cost	Total
_____/_____/_____	_____	_____	___	_____	_____
_____/_____/_____	_____	_____	___	_____	_____
_____/_____/_____	_____	_____	___	_____	_____
				Subtotal	_____
				Adjustment	_____
				Insurance Payment	_____
				Patient Responsibility	_____

Provider Signature
Date: _____

Patient Signature
Date: _____