From

Practice Name
Practice address line 1
Practice address line 2

Statement for Insurance Reimbursement

Statement Number: #000000

Issued Date:

To
Responsible Party Full Name
Responsible Party Address Line 1
Responsible Party Address Line 2

Client
Patient/Client Full Name
Date of Birth:
Client Phone Number
Client Email Address

Responsible Party
Responsible Party Full Name
Responsible Party Phone Number
Responsible Party Email Address

Insured Member
Insured Full Name
Insurance Company Name
Member ID: #000000
Group Number: #000000

Provider
Provider Full Name
NPI: #0000000000
Provider Email Address
License: #000000

Practice
Tax ID: 000-00-0000
NPI 2: Enter if applicable

DX	Diagnosis Code	Description
1	Add ICD-10 Code	Description of Diagnosis
2	Add ICD-10 Code	Description of Diagnosis
3	Add ICD-10 Code	Description of Diagnosis

Date	POS	Service (CPT Code)	DX	Description	Units	Fee	Paid
			1	Description of item/service			

Total Fees:

Total Paid:

Make Payments to: Client/Patient Full Name