



Statement for Insurance Reimbursement

Provider Name	
Provider Email	
National Provider Identifier	
Tax Identification Number	
Signature and Date	

Place of Service	
Telephone Number	

Name of Patient	
Patient's Date of Birth	
Patient's Address	
Patient's ICD-10 Diagnosis Code	

Date	CPT Code	Description (Insurance Place of Service)	Charges
		Total Charges:	
		Total Paid:	

*****PATIENT HAS PAID BALANCE IN FULL*****

Please provide payment directly to the patient