Detailed Itemized Receipt for Medical Expenses

Provider Information

Provider/Clinic/Hospital Name:	_____	Provider Phone:	_____
Provider Address:	_____		

Patient Information

Patient Name:	_____	Date of Birth:	_____/_____/_____
Patient ID/Account #:	_____	Insurance/Policy #:	_____

Service Details

Date of Service	Description of Service	Procedure/Code	Quantity	Unit Cost	Total Cost
__/__/____	Initial Consultation	99201	1	$100.00	$100.00
__/__/____	Blood Test: CBC	85027	1	$45.00	$45.00
__/__/____	Prescription Medication	RX1234	30	$2.00	$60.00
				Subtotal	$205.00
				Payments Received	($50.00)
				TOTAL BALANCE DUE	**$155.00**

Additional Notes

_____

_____

Provider Signature

Signature:	_____	Date:	_____/_____/_____