MEDICAL RECORD / INSURANCE CLAIMS

Patient's Name _____ Insurance Co _____ Year _____

DATE	SERVICE	DOCTOR/ FACILITY	BILLED AMOUNT	DATE CLAIM PROCESSED	PPO DISCOUNT	ALLOWABLE AMOUNT	Amount Paid by Insurance	AMOUNT OUT-OF-POCKET Deductible / Coinsurance		AMT PAID BY ME TO DR	DATE / NOTES

TOTALS

Total Out-of-Pocket

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