STATEMENT FOR INSURANCE REIMBURSEMENT

Name of the client:

DOB:

Address:

Phone number:

Practice Name:

Treating clinician:

NPI #:

Statement number:

Issued date:

Diagnostic Codes:

Date of service	Location and location code	CPT code	Units	Modifiers	Fee	Amount paid by client

Total amount paid by client:

Clinician's signature:

Date:

Client's signature:

Date: