Medical Bill Overview Form

Client Id: COG-_____

Client Last Name: _____

Insurance Company: _____

Insurance Company Phone Number: _____

Insurance Company Contact: _____

Medical Provider	ID #	Bill	Ins. Pmt	Pers.Pmt	Call Corrections, Write offs, Grants	Balance Due

Total

Surgery Estimations:

Estimated Services:	
Estimated Insurance Pmt:	
Balance Owed:	
Grants/Aid:	
Fundraising:	

STF #0008