Itemized Statement Form

PATIENT INFORMATION

Patient name	Member name
Address APT#	Member number
City ST ZIP	☎ Cell XXX-XXX-XXXX ☎ Home XXX-XXX-XXXX
Date of services MM / DD / YYYY	E-mail

PROVIDER INFORMATION

Name	TAX ID
Address	☎ Phone

ITEMIZED STATEMENT OF SERVICES

CPT	DESCRIPTION	DX	CHARGES

TOTAL

Did you have signs, symptoms, or treatment of this condition before joining POH? ☐ Yes ☐ No
Is this amount discounted? ☐ Yes ☐ No (POH only reimburse amount upto medicare payment schedule.)
Did you receive treatment from a family member? ☐ Yes ☐ No

Patient signature

MM / DD / YYYY
Date

IMPORTANT: FAILURE TO COMPLETE AND SUBMIT THIS FORMS WILL RESULT IN DELAYED PROCESSING.