Hospital Bill Request Template

Patient Information:

- Full Name: _____
- Date of Birth: _____
- Patient ID: _____
- Insurance Provider: _____

Billing Information:

- Billing Address: _____
- Phone Number: _____
- Email Address: _____

Request Details:

- Date of Service: _____
- Department/Service Rendered: _____
- Total Amount Billed: _____

Reason for Request:

(Select one or more)

- [ ] Itemized Bill
- [ ] Insurance Reimbursement
- [ ] Billing Error
- [ ] Payment Plan Inquiry
- [ ] Other: _____

Additional Notes:

_____
_____
_____
_____

Signature:

_____

Date: _____

Contact Information for Follow-Up:

- Billing Department Phone: _____
- Billing Department Email: _____