Patient Coverage Premium Invoice

Date: **[Invoice Date]**

Invoice Number: **[Invoice Number]**

Patient Information

Name: **[Patient Name]**

Address: **[Patient Address]**

Contact: **[Patient Contact Number]**

Coverage Details

Policy Number: **[Policy Number]**

Coverage Type: **[Coverage Type]**

Coverage Period: **[Start Date] to [End Date]**

Payment Details

Premium Amount: **$[Amount]**

Due Date: **[Due Date]**

Payment Instructions

Please make the payment by the due date. Payment can be made via:

- Bank Transfer
- Credit Card
- Check

For any queries, please contact us at **[Contact Information]**.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Organization Name]

[Your Organization Contact Information]