Sleep Study Billing Information

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Address: [Insert Patient Address]

City, State, Zip: [Insert City, State, Zip]

Billing Details

Procedure Code: [Insert Procedure Code]

Description: [Insert Description of Sleep Study]

Total Cost: $[Insert Total Cost]

Insurance Information

Insurance Provider: [Insert Insurance Provider]

Policy Number: [Insert Policy Number]

Claim Number: [Insert Claim Number]

Payment Information

Payment Due By: [Insert Payment Due Date]

Please send your payments to:

[Insert Billing Address]

If you have any questions regarding your bill, please contact our billing department at [Insert Contact Number].

Thank you for choosing our facility for your sleep study needs.

Sincerely,

[Your Name]

[Your Title]

[Facility Name]

[Facility Contact Information]