Insurance Co-Payment Breakdown

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Policy Number: [Insert Policy Number]

Contact Information: [Insert Contact Information]

Treatment Details

Treatment	Original Cost	Insurance Coverage	Co-Payment Amount
[Treatment 1]	[Cost 1]	[Coverage 1]	[Co-Payment 1]
[Treatment 2]	[Cost 2]	[Coverage 2]	[Co-Payment 2]
[Treatment 3]	[Cost 3]	[Coverage 3]	[Co-Payment 3]

Total Summary

Total Original Cost: [Insert Total Cost]

Total Insurance Coverage: [Insert Total Coverage]

Total Co-Payment Amount: [Insert Total Co-Payment]

If you have any questions, please contact us at [Insert Contact Information].

Thank you for choosing [Insurance Company Name].