Insurance Co-Payment Summary

Date: [Date]

Policyholder Name: [Policyholder Name]

Policy Number: [Policy Number]

Insurer: [Insurer Name]

Annual Review Summary

Service Provider	Service Date	Co-Payment Amount	Total Charges
[Provider Name]	[Date]	[Co-Payment]	[Total Charges]

Total Summary

Total Co-Payments: [Total Co-Payments]

Total Charges: [Total Charges]

Notes

[Any additional notes or important information related to the summary]

If you have any questions or require further information, please feel free to contact us at [Contact Information].

Sincerely,

[Your Name]

[Your Title]

[Company Name]

[Contact Information]