Medical Billing Cost Breakdown

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Provider: [Insert Provider Name]

Address: [Insert Provider Address]

Cost Breakdown

Description	Code	Amount
Office Visit	99213	$150.00
Blood Test	36415	$45.00
X-Ray	71046	$200.00
Total Amount		$395.00

Please review the above breakdown carefully. If you have any questions, feel free to reach out to our billing department.

Thank you for choosing our services.

Sincerely,

[Insert Your Name]

[Insert Your Title]

[Insert Contact Information]