

# Immunotherapy Billing and Insurance Details

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Address: [Insert Address]

Phone Number: [Insert Phone Number]

## Billing Information

Treatment Date: [Insert Treatment Date]

Procedure Code: [Insert Procedure Code]

Diagnosis Code: [Insert Diagnosis Code]

Total Cost: [Insert Total Cost]

## Insurance Information

Insurance Provider: [Insert Insurance Provider]

Policy Number: [Insert Policy Number]

Group Number: [Insert Group Number]

Co-payment Amount: [Insert Co-payment Amount]

## Contact Information

If you have questions regarding this billing or insurance information, please contact:

[Insert Contact Name]

[Insert Contact Phone Number]

[Insert Contact Email]

Thank you for choosing our clinic for your immunotherapy treatment.