Neurological Exam Billing and Insurance Information

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Provider Name: [Insert Provider Name]

Provider Address: [Insert Provider Address]

Provider Phone: [Insert Provider Phone]

Billing Information

Please find below the details regarding billing for your recent neurological examination:

- Exam Date: [Insert Exam Date]
- Total Charge: [Insert Total Charge]
- Payment Due By: [Insert Payment Due Date]

Insurance Information

Your visit may be covered by your insurance plan. Please review the following information to assist with your claims:

- Insurance Provider: [Insert Insurance Provider Name]
- Policy Number: [Insert Policy Number]
- Group Number: [Insert Group Number]
- Contact Phone: [Insert Insurance Phone Number]

Instructions for Claim Submission

To submit your insurance claim:

1. Complete the attached claim form.
2. Attach copies of all relevant medical documents.
3. Send the claim to the address provided by your insurance company.

Contact Us

If you have any questions regarding your bill or insurance information, please do not hesitate to contact our billing department at [Insert Billing Department Phone Number] or [Insert Billing Department Email].

Sincerely,

[Insert Your Name]

[Insert Your Title]

[Insert Clinic Name]