

HEALTH & WELLNESS CENTER OF PORT ST LUCIE INC Remittance Advice

Policy Information								
Policy Number:								
Policy Holder:								
Claim Information								
Claim Number:								
Date of Service:								
Provider:								
Date of Service	CPT Code	Description	Billed Amount	Allowed Amount	Deductible	Co-Insurance	Co-Pay	Amount Paid

Total Billed: \$

Total Allowed: \$