ACCOUNT(S) BALANCE VERIFICATION FORM

Provider Name: _____

RE: Our Client/Your Patient:

_____

Date of Birth: _____

Date of Loss: _____

We verify that with regard to the above-named patient, the following information is true and correct:

1. The total medical costs incurred to date by this patient as a result of the injuries for which we have provided treatment is: $_____

2. Dates of treatment from: _____ to: _____

3. Payments were made on the bill? ☐ Yes ☐ No

4. If payments have been made, please state the totals for how much was paid on the bill and by whom (e.g., State Farm, Premera, etc.): $

_____

5. Were there any contractual write-offs or adjustments made on the account after payment? If so, what was the amount written-off or adjusted?: $

_____

6. There is an unpaid balance currently due on the bill: ☐ Yes ☐ No

7. If so, how much?: $_____

8. Was part of this bill forwarded to a debt collection agency? If so, how much was forwarded and what is the name and telephone number of the agency?:

_____

9. If there is an outstanding balance, Check should be made payable to:

_____

10. Mailing address to send payment to:

_____

I, _____, hereby certify that the above information is true and correct as of the ____ day of _____, 20____.

Name and Title: _____