Insurance Company:

EOB Date:

Member Name:

Member ID:

Group #:

Group Name:

Insurance Company Claim ID:

Provider Name:

Provider Claim ID:

Claim Date:

Patient Name:

Date of Birth:

Date of Service:

Service	Amount Billed	Member Rate	Pending or not payable	Applied to Deductible	Copay	Amount Remaining	Plan Pays	Coinsurance	Patient Owes

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Claim Remarks: