

# EMERGENCY MEDICAL LEDGER

Patient Name: \_\_\_\_\_

Case ID: # \_\_\_\_\_

Date: \_\_\_\_\_

Total Billed **\$0.00**

Insurance Covered **\$0.00**

Out of Pocket **\$0.00**

DATE	SERVICE DESCRIPTION / PROVIDER	BILLED	INSURANCE	BALANCE
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**Notes & Payment Plan Details:**

This document is for personal budgeting purposes only.