Medical Office Guest Bill Third-Party Payment Approval

Patient Name

Patient ID/Record Number

Date of Service

Service(s) Provided

Total Bill Amount

Amount to be Paid by Third Party

Reason for Third-Party Payment

Third-Party Payer Details

Name / Organization

Contact Person

Phone / Email

Additional Notes

Patient / Guest Signature

Date

Third-Party Payer Signature

Date

Medical Office Approval

Date