

In the Court of Common Pleas of

County, Pennsylvania

Phone:

Fax:

Plaintiff Name:
Defendant Name:
Docket Number:
PACSES Case Number:
Other State ID Number:

Please note: All correspondence must include the PACSES Case Number.

Summary of Medical and/or Dental Bills

The following bill(s) has/have been sent to _____ and he/she has failed to pay it/them as ordered. Copies of the bill(s) and verification of insurance payment(s) are attached.

WE WILL NOT ACCEPT JUST A STATEMENT WITH A BALANCE. IT MUST BE ACCOMPANIED BY A COPY OF THE ORIGINAL BILL(S) AND A COPY OF THE RECEIPT(S).

<u>Payable to (Name of Health Care Provider)</u>	<u>Person Treated (Name of Spouse or Dependent Child)</u>	<u>Amount Paid by Insurance</u>	<u>Balance Due (Amount not Paid by Insurance)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I verify that the statements made are true and correct to the best of my knowledge. I understand that false statements herein are made to the penalties of 18 Pa. C.S. § 4904, relating to unsworn falsification to authorities.

Date

Signature

Service Type

Form EN-024
Worker ID