Medical Insurance Form Invoice Template

Medical Insurance Form Invoice

Insurance Company Name: _____ [State the official name of the insurance company]
Address:_____
_____
Phone no.:_____
Website:_____ [if any]
Invoice no._____
Date of Invoice:_____ [dd/mm/yy]

Customer Information: [Provide the necessary contact information and insurance policy details opted by the customer]
Name:
Address:
Medical Insurance Policy No.:
Name of Medical Insurance Policy:
Date of Application:_____ [dd/mm/yy]

Medical Insurance Form Details:

[State the essential details of the medical insurance policy]

Coverage Date	Medicaid Id no.	Premium Insured	Employee Premium Insured	Amount Reimbursed

Billing Information:

Amount payable: Insurance Agent Fee: Service Tax: Grand Amount: To be paid within:_____ to _____ [State the period within which all payments must be cleared by the customer]	Preferred Payment Options: Bank Account No._____ Bank Name:_____ Mode of Payment:_____

Signature of Customer:_____
Signature of Insurance Agent:_____