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). DOCUMENTATION OF MEDICAL EXPENSES MUST BE PROVIDED TO THE OTHER PARTY NO LATER THAN MARCH 31ST OF THE YEAR FOLLOWING THE CALENDAR IN WHICH THE FINAL MEDICAL BILL WAS RECEIVED.

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

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

Form EN-024 07/15

Service Type Worker ID