

Forensic Medical Examination Itemized Bill Description

This enclosure outlines the Forensic Medical Examination Program's description of an itemized bill. To proceed with the verification process on a bill, the bill MUST BE ITEMIZED. Therefore, please send a bill that provides the following information:

1. Provider(s) name, address and phone number.
2. Account number (if applicable).
3. Date(s) of Service (actual date services were provided).
4. A description of all the services provided (e.g. examiner's fee for the forensic medical examination, facility fee, medications, etc.)
5. Charges for each service provided.
6. Total charges.

**1. Provider
Information**

**2. Account
Number**

Account: 00010001000

ABC Hospital, LLC
1234 Your Street
Anywhere, Georgia 30005
(404) 555-4455 phone
(404) 555-5544 fax

Bill to: CVCP
104 Marietta St, Suite 440
Atlanta, Georgia 30303
Victim's Name: Jane Doe

<i>Date of Service</i>	<i>Description/Code</i>	<i>Amount</i>
07/01/2011	Forensic Medical Examination	\$ 250.00
07/01/2011	Facility Fee	\$ 175.00
07/01/2011	Anoscopy CPT 46600	\$ 134.04
07/01/2011	Rape Kit	\$ 5.75
07/01/2011	Ceftriaxone 250 mg IM	\$ 25.00
07/01/2011	Azithromycin 1 gram PO	\$ 10.00
07/01/2011	Viracept 1250 mg PO	\$ 30.00
07/01/2011	Chlamydia CPT 87110	\$ 37.91
Total Charges		\$ 667.70

**3. Dates of
Service**

**4. Description
of Services**

**5. Cost per
Service**

6. Total Charges