Person Treated (Name of Spouse or Dependant Child): _____

Date of Treatment	Payable to (Name of Healthcare Provider)	Total Bill	Amount Paid by Insurance	Balance not paid by Insurance	Amount paid by Petitioner	Amount due from Defendant	Date Defendant Notified

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 authorites.

_____ _____

Signature Date