

[Your Name]  
[Your Address]  
[Your Phone Number]  
[Your Email]

[Date]

[Recipient Name/Claims Adjuster]  
[Insurance Company/Organization Name]  
[Address]

**RE: Itemized Summary of Medical Expenses**

Claim Number: [Claim Number]  
Patient Name: [Patient Name]  
Date of Incident: [Date of Incident]

Dear [Recipient Name],

Please find below an itemized summary of the medical bills and expenses incurred as a result of the incident mentioned above. Copies of the original invoices and receipts are attached for your review.

<b>Date of Service</b>	<b>Provider/Facility Name</b>	<b>Description of Service</b>	<b>Amount Billed</b>
[Date]	[Provider Name]	[e.g., Emergency Room Visit]	[\$[0.00]]
[Date]	[Provider Name]	[e.g., X-Ray/Radiology]	[\$[0.00]]
[Date]	[Pharmacy Name]	[Prescription Medication]	[\$[0.00]]
[Date]	[Provider Name]	[Physical Therapy Session]	[\$[0.00]]
<b>Total Medical Expenses:</b>			<b>[\$[0.00]]</b>

In addition to the medical bills listed above, I have included documentation for the following out-of-pocket costs:

- Mileage to/from appointments: [Total Miles] miles
- Parking fees: \$[Amount]
- Medical supplies/braces: \$[Amount]

Please update my file with this information. If you require further documentation or have any questions, please contact me at [Your Phone Number].

Sincerely,

[Your Signature]  
[Your Printed Name]

Enclosures: [List of attached medical bills and receipts]