MEDICAL EMERGENCY INVOICE

Provider: [Medical Facility Name]
[Facility Address]
[City, Country, Zip]
[Tax ID/NPI]

INVOICE #: [00000]
DATE: [MM/DD/YYYY]

PATIENT / INSURED

[Full Name]
[Home Address]
[Passport Number]
[Phone Number]

TRAVEL INSURANCE PROVIDER

[Insurance Company Name]
[Policy/Certificate Number]
[Claim Number (if known)]
[Group Number]

SERVICE DETAILS

Date of Incident: [Date]
Location: [City/Country]
Admitted: [Date] | **Discharged:** [Date]

ICD/Procedure Code	Description of Emergency Services	Amount
[Code]	[Emergency Room / Consultation / Surgery]	$0.00
[Code]	[Diagnostic Tests: X-Ray, Bloodwork, MRI]	$0.00
[Code]	[Medication / Supplies]	$0.00

ICD/Procedure Code	Description of Emergency Services	Amount
[Code]	[Medical Evacuation / Transport]	$0.00

Subtotal: $0.00

Adjustments/Discounts: ($0.00)

Total Amount Due: $0.00

Diagnosis/Notes: [Brief medical summary and necessity for emergency treatment]

Payment Instructions: [Bank Name] | **SWIFT/BIC:** [Code] | **IBAN:** [Number]

This document serves as an official request for reimbursement/payment for emergency medical services rendered to a foreign traveler.