

US DEPARTMENT OF STATE
 OFFICE OF MEDICAL SERVICES
 TEMPLATE for Organizing Claims Submissions
 MED FINANCE

Item	Date of Service	Name of Service Provider/Billing Entity	Billers Phone #	Service Desc	Amount Billed	Amount Pd. By Ins.	Name of Health Insurance	Deductable	Date Deductible Paid	Date Submitted to MED Claims	Date Reimbursed by MED Claims	Receipt	Amount paid
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