

EXCESS MEDICAL BENEFITS PAYMENT RECORD

CARRIER: _____

PAGE NUMBER: _____

CARRIER'S FILE NO.: _____

EMB FILE NO.: _____

INJURED PARTY: _____

DATE OF LOSS: _____

	DATE RECEIVED	PROVIDER AND NATURE OF SERVICE	AMOUNT CHARGED	DATES OF SERVICE	AMOUNT PAID	DATE OF PAYMENT
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
PAGE TOTAL						

INDICATE WITH AN ASTERISK (*) NEXT TO THE PAYMENT OR PAYMENTS TO WHICH THE PIP DEDUCTIBLE-COPAYMENT WAS APPLIED. A SPREADSHEET THAT CORRESPONDS WITH THE PAYMENTS, INCLUDING THE TOTAL OF THE PAYMENTS, SHOULD BE ATTACHED.