Medical Enforcement Form

Case:_____ Plaintiff:_____ vs. Defendant: _____

Date of Medical Care	Type of Medical Care	Name of Patient	Total Bill	Insurance Payment	Balance after Insurance	Date other Party Notified

I, _____, verify that the facts set forth in the foregoing medical enforcement form, including all attachments thereto, are true and correct to the best of my knowledge, information, and belief. I understand that false statements herein are made subject to penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Date: _____

Signature: _____