INFORMATION TO BE PROVIDED BY THE PROVIDER

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) (DD/MM/YY): 11/12/94

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): 11/12/94

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: JOHN KELVIN

18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:

1. BACKBONE INJURY 2. LEFT LEG INJURY

19. OUTSIDE LAB? (YES/NO): YES CHARGES ($): 1000

20.

I.	II.
DATE OF SERVICE (DD/MM/YY): 07/04/93	DATE OF SERVICE (DD/MM/YY): 07/04/93
PLACE OF SERVICE OFF/HOSP/HOME): NASSAU HOME	PLACE OF SERVICE (OFF/HOSP/HOME): NASSAU HOME
PROCEDURES, SERVICES OR SUPPLIES CODE: UNUSUAL (Explain Unusual Circumstances)	PROCEDURES, SERVICES OR SUPPLIES CODE: UNUSUAL (Explain Unusual Circumstances)
DIAGNOSIS CODE (1,2): 1	DIAGNOSIS CODE (1,2): 1
CHARGES($): 500	CHARGES($): 500
FURTHER SERVICES RECOMMENDED: YES	FURTHER SERVICES RECOMMENDED: YES

III.

DATE OF SERVICE (DD/MM/YY): 07/04/93

PLACE OF SERVICE OFF/HOSP/HOME): NASSAU HOME

PROCEDURES, SERVICES OR SUPPLIES CODE: UNUSUAL (Explain Unusual Circumstances)

DIAGNOSIS CODE (1,2): 1

CHARGES($): 500

FURTHER SERVICES RECOMMENDED: YES

ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET

21. ACCEPT ASSIGNMENT (YES/NO): YES

22. TOTAL CHARGED ($): 580 23. AMT PAID ($): 500 24.BALANCE DUE ($): 80

25. SIGNATURE OR STAMP OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS AND DATE (DD/MM/YY):

SUMITH

26. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):

APOLLO HOSPITALS

27. PHYSICIANS, SUPPLIER'S BILLING NAME ADDRESS OR PHONE NUMBER:

9988669911

RECEIPTS MUST BE ATTACHED FOR EXPENSES INCURRED OR BILLS PROVIDED IF ASSIGNED

COMPLETE FOR DIRECT PAYMENT TO PROVIDER

28. I authorize payment of vision benefits to:

Doctor: Dr. SUMITH Signature: Sumith Date (DD/MM/YY): 07/05/93