INFORMATION TO BE PROVIDED BY THE PROVIDER

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) (DD/MM/YY): 04/07/13

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): 12/07/14

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: 01/01/2001

18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:

1. Air line fracture 2. Head injury

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

20.

I.	II.
DATE OF SERVICE (DD/MM/YY): 10/02/16	DATE OF SERVICE (DD/MM/YY): 10/02/16
PLACE OF SERVICE OFF/HOSP/HOME): Mia Home	PLACE OF SERVICE (OFF/HOSP/HOME): Mia home
PROCEDURES, SERVICES OR SUPPLIES CODE: Unusual (Explain Unusual Circumstances)	PROCEDURES, SERVICES OR SUPPLIES CODE: Unusual (Explain Unusual Circumstances)
DIAGNOSIS CODE (1,2): 2	DIAGNOSIS CODE (1,2): 2
CHARGES($): 500	CHARGES($): 500
FURTHER SERVICES RECOMMENDED: yes	FURTHER SERVICES RECOMMENDED: yes

III.

DATE OF SERVICE (DD/MM/YY): 23/09/14

PLACE OF SERVICE OFF/HOSP/HOME): 700 Oak Street, Brockton MA 2301

PROCEDURES, SERVICES OR SUPPLIES CODE: (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 ($): 1600 23. AMT PAID ($): 1000 24.BALANCE DUE ($): 600

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

Dr lilygrace

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

Sofia

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

tl+0506123 1

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: Lily Signature: lily Date (DD/MM/YY): 17/08/17