INFORMATION TO BE PROVIDED BY PHYSICIAN

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (DD/MM/YY): _____

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

17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DATE: _____ TO DATE: _____

18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: _____

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:

1. _____ 2. _____

20. OUTSIDE LAB? (YES/NO): _____ CHARGES ($): _____

21.

I.	II.
DATE OF SERVICE (DD/MM/YY): _____	DATE OF SERVICE (DD/MM/YY): _____
PLACE OF SERVICE OFF/HOSP/HOME): _____	PLACE OF SERVICE (OFF/HOSP/HOME): _____
(PROCEDURES, SERVICES OR SUPPLIES CODE: _____ (Explain Unusual Circumstances)	PROCEDURES, SERVICES OR SUPPLIES CODE: _____ (Explain Unusual Circumstances)
DIAGNOSIS CODE (1,2): _____	DIAGNOSIS CODE (1,2): _____
CHARGES($): _____	CHARGES($): _____
UNITS FOR DAYS: _____	UNITS FOR DAYS: _____
FURTHER SERVICES RECOMMENDED: _____	FURTHER SERVICES RECOMMENDED: _____

ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET

22. ACCEPT ASSIGNMENT (YES/NO): _____

23. TOTAL CHARGED ($): _____ 24. AMT PAID ($): _____ 25. BALANCE DUE: _____

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

_____

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

_____

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

_____

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

COMPLETE FOR DIRECT PAYMENT TO PROVIDER

29. I authorize payment of medical benefits to:

Hospital: _____ Doctor/Surgeon: _____

Signature: _____ Date (DD/MM/YY): _____