INFORMATION TO BE PROVIDED BY PHYSICIAN

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (DD/MM/YY): 05/02/13

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): 05/02/13

17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DATE: 05/02/13 TO DATE: 10/05/14

18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Mery

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:

1. Air line Fracture 2. leg injury

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

21.

I.	II.
DATE OF SERVICE (DD/MM/YY): 02/05/15	DATE OF SERVICE (DD/MM/YY): 02/05/15
PLACE OF SERVICE OFF/HOSP/HOME): Nassau Home	PLACE OF SERVICE (OFF/HOSP/HOME): Nassau Home
(PROCEDURES, SERVICES OR SUPPLIES CODE: Unusual	PROCEDURES, SERVICES OR SUPPLIES CODE: Unusual
(Explain Unusual Circumstances)	(Explain Unusual Circumstances)
DIAGNOSIS CODE (1,2): 2	DIAGNOSIS CODE (1,2): 2
CHARGES($): 500	CHARGES($): 500
UNITS FOR DAYS: 30	UNITS FOR DAYS: 30
FURTHER SERVICES RECOMMENDED: Yes	FURTHER SERVICES RECOMMENDED: Yes

ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET

22. ACCEPT ASSIGNMENT (YES/NO): Yes

23. TOTAL CHARGED ($): 1500 24. AMT PAID ($): 1000 25. BALANCE DUE: 500

26. SIGNATURE OR STAMP OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS AND DATE (DD/MM/YY): 03/05/15

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

CAB Hospitals

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

9580147668

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):