INFORMATION TO BE PROVIDED BY PHYSICIAN

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (DD/MM/YY): 06/08/12

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): 06/08/12

17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DATE: 06/08/12 TO DATE: 09/10/13

18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: CHRIS

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:

1. AIR LINE FRACTURE 2. HEAD INJURY

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

21.

I.	II.
DATE OF SERVICE (DD/MM/YY): 08/01/14	DATE OF SERVICE (DD/MM/YY): 08/01/14
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): 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 ($): 580 24. AMT PAID ($): 500 25. BALANCE DUE: 80

26. SIGNATURE OR STAMP OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS AND DATE (DD/MM/YY): 09/02/14

SMITH Ø

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

ABC HOSPITALS

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

9985673916

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): _____