

**INFORMATION TO BE PROVIDED BY PHYSICIAN**

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (DD/MM/YY): 10/11/12
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): 11/10/21
17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM DATE: 05/07/19 TO DATE: 08/09/19
18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: poppet
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:
1. Head injury 2. Hand fracture
20. OUTSIDE LAB? (YES/NO): YES CHARGES (\$): 2000
- 21.

<p>I.</p> <p>DATE OF SERVICE (DD/MM/YY): <u>16/04/17</u></p> <p>PLACE OF SERVICE (OFF/HOSP/HOME): <u>Nassu Home</u></p> <p>(PROCEDURES, SERVICES OR SUPPLIES CODE: <u>unusual</u> (Explain Unusual Circumstances)</p> <p>DIAGNOSIS CODE (1,2): <u>2</u></p> <p>CHARGES(\$): <u>1500</u></p> <p>UNITS FOR DAYS: <u>20</u></p> <p>FURTHER SERVICES RECOMMENDED: <u>YES</u></p>	<p>II.</p> <p>DATE OF SERVICE (DD/MM/YY): <u>16/04/17</u></p> <p>PLACE OF SERVICE (OFF/HOSP/HOME): <u>Nassu Home</u></p> <p>(PROCEDURES, SERVICES OR SUPPLIES CODE: <u>unusual</u> (Explain Unusual Circumstances)</p> <p>DIAGNOSIS CODE (1,2): <u>2</u></p> <p>CHARGES(\$): <u>1500</u></p> <p>UNITS FOR DAYS: <u>20</u></p> <p>FURTHER SERVICES RECOMMENDED: <u>YES</u></p>
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ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET

22. ACCEPT ASSIGNMENT (YES/NO): YES
23. TOTAL CHARGED (\$): 1800 24. AMT PAID (\$): 1000 25. BALANCE DUE: 800
26. SIGNATURE OR STAMP OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS AND DATE (DD/MM/YY):
Cruze hair
27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):
SIM Hospital
28. PHYSICIANS, SUPPLIER'S BILLING NAME ADDRESS OR PHONE NUMBER:
8687868692

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): _____