INFORMATION TO BE PROVIDED BY THE PROVIDER

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) (DD/MM/YY): 08/08/11

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): 19/10/15

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: 22/02/2002

18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:

1. optical. Surgery 2. Nerve.

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

20.

I.	II.
DATE OF SERVICE (DD/MM/YY): 02/05/20	DATE OF SERVICE (DD/MM/YY): 02/05/20
PLACE OF SERVICE OFF/HOSP/HOME): Elina.	PLACE OF SERVICE (OFF/HOSP/HOME): Elina.
PROCEDURES, SERVICES OR SUPPLIES CODE: unusual (Explain Unusual Circumstances)	PROCEDURES, SERVICES OR SUPPLIES CODE: unusual (Explain Unusual Circumstances)
DIAGNOSIS CODE (1,2): 1	DIAGNOSIS CODE (1,2): 1
CHARGES($): 800	CHARGES($): 800
FURTHER SERVICES RECOMMENDED: Yess	FURTHER SERVICES RECOMMENDED: Yes

III.

DATE OF SERVICE (DD/MM/YY): 25/10/15

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($): 800

FURTHER SERVICES RECOMMENDED: Yes.

ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET

21. ACCEPT ASSIGNMENT (YES/NO): Yes

22. TOTAL CHARGED ($): 2000 23. AMT PAID ($): 1500 24.BALANCE DUE ($): 500

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

Liza

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

ABC Hospital

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

+1 - 06054321

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: Mayo Signature: Mayo Date (DD/MM/YY): 02/08/20.