## INFORMATION TO BE PROVIDED BY THE PROVIDER

15. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) (DD/MM/YY): 06/06/10

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (DD/MM/YY): 07/07/10

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: 09/08/10

18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY CODE:

1. Air line fracture 2. Head injury

19. OUTSIDE LAB? (YES/NO): yes CHARGES ($): thausand

20.

| I. | II. |
|---|---|
| DATE OF SERVICE (DD/MM/YY): 08/02/14 | DATE OF SERVICE (DD/MM/YY): 08/02/14 |
| 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 |
| FURTHER SERVICES RECOMMENDED: yes | FURTHER SERVICES RECOMMENDED: yes |

III.

DATE OF SERVICE (DD/MM/YY): 26/10/16

PLACE OF SERVICE OFF/HOSP/HOME): 600 Oak Street, Brockton MA 2302

PROCEDURES, SERVICES OR SUPPLIES CODE: (Explain Unusual Circumstances)

DIAGNOSIS CODE (1,2): 1

CHARGES($): 500

FURTHER SERVICES RECOMMENDED: yes

*ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET*

21. ACCEPT ASSIGNMENT (YES/NO): yes

22. TOTAL CHARGED ($): 1600 23. AMT PAID ($): 1000 24.BALANCE DUE ($): 600

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

Lily grace

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

Sofia

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

tl: 0404613 21

*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: Lily Signature: [signature] Date (DD/MM/YY): 18/08/18