

TO BE COMPLETED BY PHYSICIAN OR OTHER PROVIDER OF MEDICAL SERVICES

Please complete the following information or attach itemized bills, receipts, and statements of charges from all physicians, hospitals, and any other sources. These statements must contain the following:

1. Patient's name.
2. All services or supplies provided.
3. The charge for each service provided.
4. The date each service or supply was provided.
5. Diagnosis or illness involved.

PHYSICIAN OR SUPPLIER						
Date of Illness (First Symptom), Injury (Accident), or Pregnancy (LMP):			Date First Consulted You for This Condition:		Has patient ever had same or similar symptoms? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Date Patient Able to Return to Work:		Dates of Total Disability: From _____ Through _____			Dates of Partial Disability: From _____ Through _____	
Name of Referring Physician:					For Services related to hospitalization give dates Admitted _____ Discharged _____	
Name & address of facility where services rendered (if other than home or office):					Was laboratory work performed outside your office? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Diagnosis or nature of injury. 1. 2. 3. 4.						
Date of Service	Place of Service*	Procedure Code CPT4	Fully describe procedures, medical services, or supplies furnished for each date given (Explain unusual services or circumstances)	ICD-9 Diagnosis Code	Charges	
Signature of Physician or Supplier			Accept Assignment Yes <input type="checkbox"/> No <input type="checkbox"/>		Total Charge	
Signed _____ Date _____			Your Social Security No.		Amount Paid	
Your Patient's Account No.			Your Employer I.D. No.		Balance Due	
					Physician's or Supplier's Name, Address, Zip Code, & Telephone No.	
					I.D. No.	

*Place of Service Codes

21 --Inpatient Hospital	12 --Patient's Home	32 --Nursing Facility	99 --Other Locations
22 --Outpatient Hospital	52 --Day Care Facility (PSY)	31 --Skilled Nursing Facility	81 --Independent Laboratory
11 --Doctor's Office	51 --Night Care Facility	41 --Ambulance	24 --Ambulatory Surgical Facilities