

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:

- A. Patient's name.
- B. All service or supplies provided.
- C. The charge for each service provided.
- D. The date each service or supply was provided.
- E. Diagnosis or illness involved.

PHYSICIAN OR SUPPLIER								
Date of	Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	Date First Consulted You for This Condition	Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No					
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 hospitalization dates Admitted _____ Discharged _____					
Name & address of facility where services rendered (if other than home or office)			Was laboratory work performed outside your office? <input type="checkbox"/> Yes <input type="checkbox"/> No Charges: _____					
Diagnosis or nature of illness or 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)	ICD9 Diagnosis Code	Charges			
Signature of Physician or Supplier			Accept Assignment <input type="checkbox"/> Yes <input type="checkbox"/> No		Total Charge		Amount Paid	Balance Due
Signed _____			Date _____		Your Social Security No. _____			Physician's or Supplier's Name, Address, Zip Code & Telephone Number
Your Patient's Account No. _____			Your Employer I.D. No. _____		I.D. No. _____			

*Place of Service Codes

- | | | | | | | | |
|--------|----------------------|-------|--------------------------|---------|---------------------------|------|------------------------------------|
| 1-(H) | -Inpatient Hospital | 4-(H) | -Patient's Home | 7-(NH) | -Nursing Facility | O-OL | -Other Locations |
| 2-(OH) | -Outpatient Hospital | 5- | -Day Care Facility (PSY) | 8-(SNF) | -Skilled Nursing Facility | A-IL | -Independent Laboratory |
| 3-(O) | -Doctor's Office | 6- | -Night Care Facility | 9- | -Ambulance | B- | -Other Medical Surgical Facilities |

	Date of Purchase	Prescription Number	Name of Medication	Diagnosis for Which Medicine was Prescribed	Prescribing Physician	Cost (Excluding Tax)
Complete each column for each Prescription						