

ATTENDING PHYSICIAN'S STATEMENT

Patient Name _____

Is condition due to injury or sickness arising out of patient's employment?
 Yes No

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

1 _____ 3 _____
 2 _____ 4 _____

DATES OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS
MM	From DD	YY	MM	To DD	YY							

FEDERAL TAX ID NUMBER	SSN <input type="checkbox"/>	EIN <input type="checkbox"/>	PATIENT'S ACCOUNT NO.	ACCEPT ASSIGNMENT? <small>(For govt. claims, see back)</small> <input type="checkbox"/> YES <input type="checkbox"/> NO	TOTAL CHARGE \$	AMOUNT PAID \$	BALANCE DUE \$
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SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) _____ SIGNED	NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office) _____ DATE	PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, & PHONE NO. _____
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