

TO BE COMPLETED BY PROVIDER OF SERVICES IN THE ABSENCE OF A DETAILED RECEIPT

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H	M
R	I
S	N

1. GENERAL

REFERRING PHYSICIAN'S NAME _____

TARIFF NO.	NO. SERV.	DATE	FEE
8540			
8509			
IN PATIENT HOSPITAL CARE			
FIRST DAY THIS CLAIM			
LAST DAY THIS CLAIM			
ORIGINAL ADMIT. DATE			
			TOTAL FEE

3RD PARTY LIABILITY

DIAGNOSIS FOR SERVICES AND WHERE RENDERED

OFFICE HOME O.P.D. EMERG. HOSP. IN PAT

DATE OF SERVICE _____

2. LABORATORY

Name of Facility _____
 Address of Facility _____
 Facility's Postal Code _____ Facility's Telephone No. _____
 Referring Physician's Name _____

FEE	FEE	FEE
9035 <input type="checkbox"/>	9220 <input type="checkbox"/>	9521 <input type="checkbox"/>
9037 <input type="checkbox"/>	9252 <input type="checkbox"/>	9641 <input type="checkbox"/>
9072 <input type="checkbox"/>	9264 <input type="checkbox"/>	9644 <input type="checkbox"/>
9075 <input type="checkbox"/>	9273 <input type="checkbox"/>	9663 <input type="checkbox"/>
9113 <input type="checkbox"/>	9274 <input type="checkbox"/>	9687 <input type="checkbox"/>
9141 <input type="checkbox"/>	9300 <input type="checkbox"/>	9720 <input type="checkbox"/>
9142 <input type="checkbox"/>	9304 <input type="checkbox"/>	9721 <input type="checkbox"/>
9147 <input type="checkbox"/>	9306 <input type="checkbox"/>	9836 <input type="checkbox"/>
9150 <input type="checkbox"/>	9312 <input type="checkbox"/>	9837 <input type="checkbox"/>
9184 <input type="checkbox"/>	9315 <input type="checkbox"/>	9170 <input type="checkbox"/>
9216 <input type="checkbox"/>	9470 <input type="checkbox"/>	9795 <input type="checkbox"/>

OTHER & MULTIPLE SERVICES		
NO.	TARIFF NO.	FEE

3RD PARTY LIABILITY

DATE OF SERVICE : _____

3. RADIOLOGY

Name of Facility _____
 Address of Facility _____
 Facility's Postal Code _____ Facility's Telephone No. _____
 Referring Physician's Name _____

FEE	FEE	FEE
7012 <input type="checkbox"/>	7050 <input type="checkbox"/>	7074 <input type="checkbox"/>
7014 <input type="checkbox"/>	7051 <input type="checkbox"/>	7077 <input type="checkbox"/>
7024 <input type="checkbox"/>	7052 <input type="checkbox"/>	7079 <input type="checkbox"/>
7025 <input type="checkbox"/>	7053 <input type="checkbox"/>	7083 <input type="checkbox"/>
7031 <input type="checkbox"/>	7056 <input type="checkbox"/>	7084 <input type="checkbox"/>
7036 <input type="checkbox"/>	7058 <input type="checkbox"/>	7339 <input type="checkbox"/>
7037 <input type="checkbox"/>	7059 <input type="checkbox"/>	7366 <input type="checkbox"/>
7039 <input type="checkbox"/>	7060 <input type="checkbox"/>	7403 <input type="checkbox"/>
7044 <input type="checkbox"/>	7062 <input type="checkbox"/>	7404 <input type="checkbox"/>
7048 <input type="checkbox"/>	7067 <input type="checkbox"/>	7405 <input type="checkbox"/>
7049 <input type="checkbox"/>	7073 <input type="checkbox"/>	

OTHER & MULTIPLE SERVICES		
NO.	TARIFF NO.	FEE

3RD PARTY LIABILITY

DATE OF SERVICE : _____

4. OPTOMETRY, CHIROPRACTIC OR OTHER SERVICES

Name of Facility _____
 Address of Facility _____
 Facility's Postal Code _____ Facility's Telephone No. _____
 Referring Physician's Name _____

TARIFF NO.	NO. SERV.	DATE	FEE
			TOTAL FEE

DIAGNOSIS FOR SERVICE RENDERED
 (PLEASE PROVIDE A DESCRIPTION OF SERVICE RENDERED WHERE A TARIFF NO. DOES NOT EXIST)

DATE OF SERVICE : _____