MEDICAL BUSINESS MANAGEMENT

PATIENT BILLING

BILLING: PLEASE FILL IN WITH CODE REQUIRED
PRIVATE (P), NO GAP (N) KNOWN GAP (K) SCHEDULE FEE (S)
MEDICARE ONLY (M) DVA (D) WORKCOVER (W)

DR:

HOSPITAL STICKER/PATIENT DETAILS		
NAME: DOB: MALE/FEM: UNIT RATE: ADDRESS: MCARE NO: HEALTH INSUR PROV: NO: DVA Y/N – NO:	DATE OF SERV.	
	SURGEON	
	HOSPITAL	
	PRE OP:	
	ITEM NOS:	
	AGE MOD	
	PHYS MOD	
	EMERG/AHRS	
	BILLING: P,N,K,S,M,D,W	TIMES

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	PRE OP:	
	ITEM NOS:	
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	EMERG/AHRS	
	BILLING: P,N,K,S,M,D,W	TIMES

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