AE Medical Billings Inc.

HOSPITAL NAME	PHYSICIAN BILLING FORM HOSPITALS REPORT OF PATIENT VISITS	PHYSICIAN NAME

PATIENT LABEL	OHIP SERVICE CODE	DATE OF SERVICE (MM-DD-YY)	DIAG. CODE	NO. OF UNITS (If required)	REFERRING PHYSICIAN NAME AND MOH REG NO. DOA, SITE#, PATIENT STATUS
					REF DR:
					ADMIT DATE (mm-dd-yy):
					INPATIENT / OUTPATIENT
					REF DR:
					ADMIT DATE (mm-dd-yy):
					INPATIENT / OUTPATIENT
					REF DR:
					ADMIT DATE (mm-dd-yy):
					INPATIENT / OUTPATIENT
					REF DR:
					ADMIT DATE (mm-dd-yy):
					INPATIENT / OUTPATIENT
					REF DR:
					ADMIT DATE (mm-dd-yy):
					INPATIENT / OUTPATIENT

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