AE Medical Billings Inc.

PHYSICIAN BILLING FORM - HOSPITALS

REPORT OF PATIENT VISITS

DATE OF SERVICE

YEAR		MONTH		DAY	

PHYSICIAN NAME	**HOSPITAL NAME**

PATIENT NAME		**DOB (mm/dd/yy)**	HEALTH RECORD NO	VC	PATIENT STATUS (I/O)	OHIP SERVICE CODE	DIAG. CODE	NO. OF UNITS	DATE OF ADMISSION	REFERRING PHYSICIAN NAME AND MOH REG NO. (for Consultation only)
SURNAME	GIVEN NAME									