AE Medical Billings Inc.

DATE OF SERVICE

YEAR		MONTH		DAY	

PHYSICIAN BILLING FORM – PRIVATE PRACTICE

REPORT OF PATIENT VISITS

PHYSICIAN NAME

PATIENT NAME		DOB (mmm/dd/yy)	HEALTH CARD NO	VERSION CODE	OHIP SERVICE CODE	DIAG. CODE	NO. OF UNITS (If required)
SURNAME	GIVEN NAME						