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2		3 PATIENT CONTROL NO.				4 TYPE OF BILL	
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV. D.	8 N-C.D.	9 C-I.D.	10 L-R.D.	11

12 PATIENT NAME												13 PATIENT ADDRESS											
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14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION			21 D HR	22 STAT	23 MEDICAL RECORD NO.			CONDITION CODES				31		
				18 HR	19 TYPE	20 SRC						24	25	26	27	28	29	30

32 OCCURRENCE DATE	33 CODE	34 OCCURRENCE DATE	34 CODE	35 OCCURRENCE DATE	35 CODE	36 CODE	37 OCCURRENCE SPAN FROM THROUGH	

38			39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	b	c	d	.	.	.	.	.
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42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
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50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
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**DUE FROM PATIENT**

57	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	OTHER DIAG. CODES			74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
				71 CODE	72 CODE	73 CODE					

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		
			C		D		83 OTHER PHYS. ID
					E		

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
	X	