THIS FROM MUST BE COMPLETED BY A DOCTOR PROVIDING A <u>SECOND</u> OPINION
DOCTORS WHO PROVIDE THE FIRST OPINION OR WHO MAY PERFORM THE SURGERY CANNOT USE THIS FORM

CLAIM FOR PHYSICIAN'S SERVICES

Date Examined ____

Is this a possible Workmen's or Veteran's Compensation Case? ___ Yes ___ No

DIAGNOSIS: ____

____

____

____

Does the patient require elective surgery? ___ Yes ___ No

Comments: ____

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____

Specific services rendered and fee: ____

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____

PHYSICIAN'S NAME ______________________

ADDRESS ______________________

____

I, A DULY LICENSED PHYSICIAN, PERSONALLY PERFORMED THE ABOVE SERVICES.

______________________ PHYSICIAN'S SIGNATURE ________ DATE

______________________ PHYSICIAN'S IDENTIFICATION NO.

IMPORTANT: MAKE CERTAIN THAT ITEMIZED BILLS ARE ATTACHED TO SUPPORT ALL CLAIMS