Superbill Medical

Insurance Co.:	Hospital:
Refferer:	Address:
Copy Amt:	Phone:
Check or Cash:	Doctor:
Authorization:	Case:

NAME: _____ ADDRESS: _____ PHONE: _____

OFFICE SERVICES	CODE	FEE	PROCEDURE	CODE	FEE	TEST	CODE	FEE

DIAGNOSES	CODE	FEE	LABS	CODE	FEE	ORDERS	CODE	FEE