Insurance Co.: _____   Hospital: _____
Referrer: _____   Address: _____
Copay Amt.: _____   Phone: _____
Cash or Check: _____   Doctor: _____
Authorization: Case #:

Superbill

Patient Name: Address: Phone:

Office Services	Code	Fee	Procedures	Code	Fee	Tests	Code	Fee

Diagnoses	Code	Fee	Labs	Code	Fee	Orders	Code	Fee