RODING HEALTHCARE LTD

BILLING FORM

Service Provider : ***Date:*****_____/ _______/______**

Patient Name:

Surname ***First name*** ***Other names.***

Age: ***Staff ID No.*** ***Gender: M F*** ***ROHL ID No.***

Type of Service Inpatient ☐ outpatient ☐	***Authorization Code/Notification Code:***	***Authorization by:***	***DIAGNOSIS:***	***Admission duration***

(mark as appropriate) ***(if appropriate)***

S/N	***Prescription/Laboratory/Radiological Investigation/Procedure***	***Quantity***	***Amount***
Total			

Doctor's Name:**____________________________** ***Signature/Date:*****____________________**

Acknowledgement: I hereby confirm that I have received the above stated treatment.

Patient's Name :**____**

Company Name:**____**

Patient's Signature and Date:**__________________________________**

ROHL