



Group Name: \_\_\_\_\_

Rendering Provider : \_\_\_\_\_

Billing Provider: \_\_\_\_\_ (if other than rendering)

<b>Date of Service</b>	<b>PATIENT NAME</b>	<b>CPT</b>	<b>ICD 10 DX</b>	<b>Location</b>	<b>New Client?</b> If Yes, please enter DOB and insurance.