

The Benchmark for Quality Care

PROFESSIONAL COURTESY REQUEST FORM

PATIENT NAME:		
PATIENT ACCOUNT NUMBER:		
Please fill in the amount you wish to discount for each charge:		
Date of service:	_Total Charge \$	PC Amt:
Date of service:	_Total Charge \$	PC Amt:
Date of service:	_Total Charge \$	PC Amt:
Reason Required Prior to Approval:		
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		_
Physician Name:	Date:	
Physician Signature:		
Billing Mgr. Approval:		
Initials:	Date:	
Revised 1/1/2018		