



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:

Physician Name: _____ Date: _____

Physician Signature: _____

Billing Mgr. Approval:

Initials: _____

Date: _____