Tri-County Medical

¡ 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:

_____

Physician Name: _____ Date: _____

Physician Signature: _____

Billing Mgr. Approval:

Initials:_____ Date: _____

[i] Revised 05/11/2012