

**PROFESSIONAL COURTESY REQUEST FORM**

PATIENT NAME: \_\_\_\_\_

PATIENT DOB: \_\_\_\_\_

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: \_\_\_\_\_