

HEAD START MEDICAL BILLING FORM

Stanislaus Medical Society Head Start Post Office Box 576007 Modesto, CA. 95357	PATIENT	BIRTHDATE	SEX					
	ADDRESS							
	REFERRED TO Health Services Agency 820 Scenic Drive, Modesto	APPOINTMENT <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; height: 20px;"></td> <td style="width: 50%; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: small;">HOUR</td> <td style="text-align: center; font-size: small;">DATE</td> </tr> </table> </td> <td style="width: 50%; border: none;"></td> </tr> </table>		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; height: 20px;"></td> <td style="width: 50%; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: small;">HOUR</td> <td style="text-align: center; font-size: small;">DATE</td> </tr> </table>			HOUR	DATE
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REFERRING AGENCY
Stanislaus County Office of Education – Head Start

COMPLAINT, SYMPTOMS, PROBLEM

Nurse's Signature			Date:	
DATE	DIAGNOSIS	DESCRIBE SERVICE	RVS No.	FEE
		Office Visit		21.00
		Chest X-ray		57.50
		INH		4.50
		Vitamin B6		5.00
		Lab		22.00
		PPD		25.00

Date: _____ Physician's Signature: _____

Distribution: White – Physician Yellow – Return to Nurse Pink – File

Mandatory
Revised 1/14
CF/H-13c