Medicine

Date:

Medical/Legal & Consulting Billing Form

From

Provider:

Provider #/Division:

Phone:

Box #:

Party to Bill

Firm:

Attention:

Address:

City:

State:

Zip Code:

Email:

Phone:

Fax:

Regarding Patient or Case:

Service Information

Date	Specific Services Provided	Time	Hourly Rate	Total

*Provider's Signature:

Total Charge: $ 0.00

* Provider's **typed signature is acceptable** if submitting via email. No need to print and scan a copy of this form.
- Please save a copy for your records and email a digital copy to FinanceMedLegalConsulting@cumedicine.us
- For additional information please call 303-493-8223
- If not available electronically, forms can be submitted to Medical/Legal Billing, Campus Box A069

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