CERTIFICATE NO. _____

LODGE/NEST NO. _____

VAL / PLAN CODE _____

PREMIUM _____

CLAIM ENTRY NO. _____

CHECK NO. _____

DATE OF CHECK _____

CROATIAN FRATERNAL UNION OF AMERICA

100 Delaney Drive, Pittsburgh, PA 15235

SURGEON'S REPORT OF OPERATION

Patient's Name _____ Age _____

Address _____City _____State _____ Zip Code _____

1. Date of First Treatment _____ 20 ___ Date of Operation _____ 20 ___

2. Operated in Office ☐ Hospital ☐ Confined to Hospital from _____ 20 ____ to _____ 20 ___

3. Diagnosis Before Operation _____

4. In Patient ☐ Out Patient ☐

5. Describe And Give Full Particulars Of Operation (Use CPT Codes) _____

_____

6. If Blood Transfusions Were Given State Exact Dates_____

7. Diagnosis After Operation _____

   Use CPT Codes _____

8. Have Any Previous Operations Been Performed? _____ If yes, give types and dates.

   Operation _____Date_____20 ___

   Operation _____Date_____20 ___

Graduate of _____ Year _____

City and State _____

_____ , M.D.

Date _____ _____ Signature

FOR OFFICE USE ONLY

DATE   AMOUNT OF PAYMENT

_____   Approved: ☐

_____   Rejected: ☐

MEDICAL CODE _____   Date: _____

_____   Medical Advisor: _____