Doctor Name ____________________

Doctor PRACID ______________

Client Number ______

Doctor Number ___

M.M.S. MEDICAL MANAGEMENT SERVICES LTD.

TYPE 2 PERSONAL DATA SEGMENT/TEXT/MEDICAL RECIPROCAL CLAIMS SHEET

Page ____________

Date ____________

Surname	First Name	Middle Name	Gender	DOB			Address	City	Prov	Postal Code	Claim #
				DD	MM	YY					

Sex	Prov	PHN	Service Date			Calls	HSC	Amount	DX 1	DX 2	DX 3	Referral PRACID	Claim Type	Facility #	Func Centre	Mod 1	Mod 2	Mod 3	Act Code	ENC #	Home	Hosp Adm Date		
			DD	MM	YY																	DD	MM	YY

Text Lines

Surname	First Name	Middle Name	Gender	DOB			Address	City	Prov	Postal Code	Claim #
				DD	MM	YY					

Sex	Prov	PHN	Service Date			Calls	HSC	Amount	DX 1	DX 2	DX 3	Referral PRACID	Claim Type	Facility #	Func Centre	Mod 1	Mod 2	Mod 3	Act Code	ENC #	Home	Hosp Adm Date		
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Text Lines

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Text Lines