MEDICARE

ZENITH MEDICARE LIMITED

MONTHLY ENCOUNTER FORM

HEALTH CARE PROVIDER: _____

PROVIDER ID: _____

MONTH: _____ YEAR: _____

NO OF PATIENT PANEL: _____

TOTAL NUMBER OF VISIT: _____

S/N	DATE	NAME OF ENROLLEE	AGE	SEX	ID NO	DIAGNOSIS	OPD/ ADMISSION	PRE-AUTH. No	ENROLLEE'S SIGN.

NAME & SIGNATURE OF MEDICAL DIRECTOR