Provider Form
for Direct Settlement of Outpatient Services

Please append this document to the invoices

Healthcare Provider

Name:_____

City: _____ Country: _____

Patient

Name:_____

Date of Birth: _____

Henner ID number: _____

Services rendered

Date of care: _____

Diagnosis: _____

_____

Total amount of expenses: _____

Amount paid by patient: _____

Amount due by Henner: _____

Patient's authorization

I hereby acknowledge that I have received care and/or services from the above-mentioned Healthcare Provider. I have been informed of the total amount of the expenses and of care and/or services not covered by Henner and therefore payable by me directly to the Provider. I hereby authorize my doctor to indicate the diagnosis on this form and give my consent regarding the processing of the medical data.

Provider's Signature and Stamp: Patient's Signature: