PATIENT IDENTIFICATION *(For mechanical imprinting, typewriter or hand entry)*	DATE OF ADMISSION/ OUTPATIENT TRMT	AUTHORITY FOR ADMISSION/OUTPATIENT TRMT	PATIENT CATEGORY
	INVOICE MAILING ADDRESS *(Include ZIP Code)*		
	REMARKS/INFORMATION FOR PREPARATION OF DD FORM 7 & 7A		

CONTROL CODES (Post appropriate code to PATIENT'S DAILY HOSPITAL RECORD below)

A - Admission
B - On Pass *(In excess of 24 hours but less than 72 hours)*
C - Leave
D - Discharge
E - AWOL
H - Patient Category Change
K - TDY or PCS
O - Outpatient Clinic Visit
R - Remaining in Hospital (End of Month ONLY)
S - Subsisting Elsewhere
T - Continuing Hospitalization (First day of Month ONLY)

PATIENT'S DAILY HOSPITAL RECORD

DAY OF MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MONTH																															
MONTH																															
MONTH																															

DAILY RATE OF CHARGES

HOSPITAL	SUBSISTENCE ONLY	OUTPATIENT CHARGE

BILLING DATA

DATE	DESCRIPTION *(Enter period covered by charges, etc)*	TOTAL DAYS	DAYS CREDIT	DAYS CHARGED	INVOICE OR BILL NUMBER	CHARGES			PAYMENT RECEIVED	BALANCE DUE
						HOSPITALIZATION	OTHER *(Including Outpatient Charges)*	TOTAL		