

ALL INFORMATION WILL BE HELD STRICTLY CONFIDENTIAL

I am Ready for the Next Step....

Physician/Owner(s): _____

Physician/Owner e-mail: _____

Contact Person: _____

Contact e-mail: _____

Legal Entity Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (____) _____ - _____

Fax #: (____) _____ - _____

Please Contact Me

I am enclosing the attached application package. Please review my application and have Inga Ellzey contact me to discuss the billing fees and discuss the billing service contract.

- I am ready to sign up!** Please have Inga Ellzey call me at the following number:

Phone: (____) _____ cell office home
 in the evenings during the day Between: _____ and _____ AM/PM

- I prefer that my staff not know about my inquiry.** Please call me at the following number:

Phone: (____) _____ cell office home
 in the evenings during the day Between: _____ and _____ AM/PM

- I need more information.** Please have Inga Ellzey call me at the following number:

Phone: (____) _____ cell office home
 in the evenings during the day Between: _____ and _____ AM/PM

TO RESPOND: Confidential Fax: 1-407-678-5751

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Billing Service Application

(Please answer all questions completely and to the best of your knowledge. The information provided will be held in the strictest of confidentiality and will be personally reviewed by Inga Ellzey.)

Needs Assessment

1. Are you presently using a billing service?

No (If no skip to question #2)

Yes (If yes, how many years? _____)

Why are you interested in changing companies? _____

2. Why are you considering a billing service? (Check all that apply)

A/R getting too high

Can't find qualified people

Key individual who did billing left

Don't want to invest in computer upgrades

Need space now occupied by billing staff

Don't think present staff is doing the best job and may be writing off things they should be appealing

Other (explain)

3. Is your staff supportive of you using a billing service?

Yes

No (explain) _____

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Practice Profile

1. How many total providers are in your practice? _____ (Indicate how many below)

- _____ Physicians (full-time)
- _____ Physicians (part time)
- _____ Nurse Practitioners (full-time)
- _____ Nurse Practitioners (part time)
- _____ Physician Assistants (full-time)
- _____ Physician Assistants (part time)
- _____ Mohs Surgeons (full-time)
- _____ Mohs Surgeons (part time)
- _____ Dermatopathologists (full-time)
- _____ Dermatopathologists (part time)

2. Are you planning to add any providers in the coming six months?

Yes No If Yes, indicate the number below.

Physician Assistants (how many) _____

Nurse Practitioners (how many) _____

Physicians (how many) _____

Mohs Surgeons (how many) _____

Dermatopathologists (how many) _____

3. How many total offices do you have including your main office?

_____ Total

Are they all located in the same state?

Yes No

If No, please list the other states _____

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Revenue Profile

1. How many patients do you see weekly between all providers?

_____ Patients per week (total)

2. What were your **gross** charges for the previous calendar year? (*Gross charges are the amount billed before contractual adjustments are made.*)

And how many patient claims/procedures did this represent?

Gross charges

this represents

(circle one)

\$ _____ in year 2010 _____ claims/procedures

3. What were your **net** receipts for the following calendar years? (*Net receipts is the total deposits in the bank...actual collections*)

And how many patient claims/procedures did this represent?

Net receipts

\$ _____ in year 2010

Of this total, what were the net receipts for the following categories...

Pathology Services (CPT 88304-88305) \$ _____

Mohs' Surgery (CPT 17311-17315) \$ _____

Cosmetic Services \$ _____

Cash/Time of Service Payments \$ _____

All other services \$ _____

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Carrier Profile

1. Are you a Medicare participating provider?

Yes No

If Yes, approximately what percentage of your patients are Medicare? _____ percent

2. Do you bill the Medicare allowed amount?

Yes No

3. Do you bill non- Medicare patients at a different rate?

Yes No

If Yes, indicate approximately what percentage above Medicare rates? _____ percent

4. Do you participate with any capitated insurance plans?

Yes No

If Yes, indicate how many _____

5. Do you participate with any managed care insurance plans?

Yes No

If Yes, indicate how many _____

6. Do you accept Medicaid?

Yes No

If yes, does Medicaid represent more than 5% of your practice?

Yes No

7. Do you accept CHAMPUS/Tricare?

Yes No

If yes, does CHAMPUS/Tricare represent more than 5% of your practice?

Yes No

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Procedure Profile

1. What surgical procedures do you frequently perform? (check all that apply)

- | | | |
|---|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Mohs' | <input type="checkbox"/> Flaps | <input type="checkbox"/> Grafts |
| <input type="checkbox"/> Excisions | <input type="checkbox"/> Biopsies | <input type="checkbox"/> Destructions |
| <input type="checkbox"/> Intermediate/Complex repairs | <input type="checkbox"/> Other | 1. _____ |
| | | 2. _____ |
| | | 3. _____ |

2. Please provide a list of your 20 most commonly billed procedures/services, not including E/M services. (Use CPT codes).

Do not guess. You should be able to run this report from your billing software. This is commonly called a Procedure Productivity Report. Please include a copy of the report.

	Code	# of procedures performed (or total revenue)
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____
11.	_____	_____
12.	_____	_____
13.	_____	_____
14.	_____	_____
15.	_____	_____
16.	_____	_____
17.	_____	_____
18.	_____	_____
19.	_____	_____
20.	_____	_____

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Pathology Profile

1. Do you read your own slides?

Yes No

If yes, how many per year? _____ (specimens)

2. Do you make your own slides in-house?

Yes No

If yes, how many per year? _____ (slides)

3. Is the pathology lab a legal part of your practice?

Yes No

If no, explain the legal structure of the lab

Separately incorporated

Other (explain) _____

4. Would you like to learn more about assistance with setting up an in-house slide-making lab for your practice?

Yes No

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Technology Profile

1. Does your office currently utilize a lock box (bank) to receive payments and EOMBs?

Yes No

2. Does your staff have regular access to e-mail and the internet?

Yes No

3. Do you have a paper document scanner in the office?

Yes No

4. What Billing (i.e., Practice Management) software do you presently run?

Name: _____

Are your providers currently utilizing a certified EMR/EHR system?

Yes No If Yes, What system? _____

If No, are you looking for a solution in the near future?

Yes No

5. Do you currently e-Prescribe?

Yes No

If not, when do you plan to start? 2011 2012 Not interested

6. Does your office participate in PQRS (formerly PQRI)?

Yes No

My signature below signifies that the information provided on this application is accurate and correct to the best of my knowledge.

Signature of Provider Applicant