PRACTICE ANALYSIS FORM

Please fill out this form and fax it to 325-267-2601

-Procedures (check one):
o Chiropractic Manipulations
o Chiropractic Manipulations, Physical Therapy, Massage Therapy, Acupuncture
o Chiropractor - Physical Therapist - Nurse Practitioner/Physician Integration
o Other (explain): _____

-Claims submitted per month (how many) _____
a) % Commercial Insurances: _____
Which one are you in-network with? _____
Other networks (for ex. Multiplan): _____
b) % Medicare: _____
c) % Personal Injury: _____
d) % Workers' Compensation: _____
e) % Triwest

-How are claims submitted? _____
-Do you have an EHR system & what is the name of the program? _____

-How many Patient Statements are prepared per month: _____

-Accounts Receivable Aging in $:
a) <120 days: _____
b) >120 days: _____

-Are you interested in:
o A/R Aging Recovery (old claims cleanup only)
o All the billing (claims submission, follow-up, denial resolution, patient statements)
o Other: _____

-How soon do you plan to outsource? _____

-Current billing, collections & receivable problems & any other comment:
_____
_____
_____
_____

-Practice Name: _____
-Your Name, Title and Contact: _____

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