Med Advent
THE MEDICAL BILLING & COLLECTION EXPERTS

BILLING ASSESSMENT FORM

Contact Information:

Name: _____

Practice Name: _____

Speciality: _____ No. of Providers: _____

Practice Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell: _____ Fax: _____

Email: _____

Current Billing Information:

Current System (PMS): _____

Currently how you are processing your claims? *(If outsourcing to billing company please provide name)*

_____

Number of Claims Per Month: _____ Avg. Claim Amount: _____

Total Collected Amount Per Month: _____ Avg. Cost per Claim: _____

Do you charge No Show/Cancelled/Void etc? _____

Percent of A/R below 90 days: _____ Percent of A/R above 90 days: _____

Services Required:

1. Virtual Front Desk
2. Medical Billing Services
3. Denial Management Services
4. Medical Transcriptions

Optional/Other Services:

1. Patient Statement Mailing Services
2. Data Import *(Import Patient Demographics and related information from previous system into our system, or alternatively you can start fresh with a clean practice database)*
3. Provider Credentialing Services
4. Back-end technical support for admin staff in Clinic

Comments/Questions:

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Send completed form to support@medadvent.com or fax it to 713.929.3621. Once Med Advent receives completed checklist. Our representative will get in touch with your practice staff/administrator for further processing.