



This form is not a contract. This is a request for information to provide a No-Obligation Rate Quote. The information provided here will be kept private and will not be shared or distributed to any third party.

## Physician Survey

### General Information

Practice			
Physician Name		Phone	
Contact Name		Phone	
Address			
E-Mail		Fax	

### Practice & Claims Information

# of Staff			# of Providers		
# of Patients (Per Month)					
<b>Claims processed PER MONTH</b>					
Medicare			Medicaid		
Blue Cross/ Blue Shield			HMO		
Commercial			CHAMPUS/Tri Care		
Worker's Comp.					
Total gross billing	\$			Total collections	\$
Current total A/R	\$			% of claims rejected or denied	%
Total outstanding claims			Avg. # of days for reimbursement		
<b>A/R Aging Information</b>					
1-30 Days	\$	31-60 Days	\$	61-90 Days	\$
				91-120 days	\$

### Electronic Claims Processing Information

Do you use electronic claims processing?	YES / NO	Clearinghouse	
Medicare		Medicaid	
Blue Cross/ Blue Shield		CHAMPUS/Tri Care	
Commercial		HMO	
Name of Software used			