Physicians Billing Management Corporation
Client Forms
Page 1

- **Please complete the following pages to the best of your knowledge. If a specific field does not apply to your practice, you may leave it blank. Some of the pages are repetitive, (ie locations. If you only have one location, leave the other pages blank).**

General Practice Information:

1. Practice Name as it is to appear on all correspondence:

2. Practice address where all payments and correspondence should be sent:

3. Phone # for billing inquiries:	( ) -

4. Federal Tax ID Number:	

5. Small balance amount to automatically write-off. (i.e., claims under $2.00)	$

6. If this is a Yes group practice, please list the Group Practice Provider Numbers Below: (Individual provider numbers are requested on the following pages)	
Blue Cross/Blue Shield	
Medicare	
Medicaid	
Community Mutual/Anthem	
Worker's Compensation	
Other	

7. What is your practice's fiscal year ending date?	

Physicians Billing Management Corporation
Client Forms
Page 2

Location of Services Information:

- A location is any hospital, nursing home, or office where services are rendered. Please fill out for each location. If you run inpatient out of location forms, simply xerox off and fill out as many forms that are needed for your group. Staple to this packet.

LOCATION 1:

Location Name:	
Please Designate a Two Letter Alphanumeric Code (ex: the first two letters of your location name):	
Location Address:	
Location Phone #	
Location Phone # for Patient Billing Calls	

Is location for:

☐ Inpatient Services Only
☐ Outpatient Services Only
☐ Both Inpatient and Outpatient

Would you like to track both inpatient revenue and outpatient revenue for this location separately? ☐ Yes ☐ No

*If YES, a separate location and code must be entered (one for inpatient and one for outpatient)

Default Physician: (if there is only one physician in the group that practices at this location, we can default his name into this location.) If not applicable, leave blank.
Default physician name:
CLIA#:

Statement types to be used: (Place a check next to the type you would like.)	
Family:	
Patient:	

Location of Services Information:

- A location is any hospital, nursing home, or office where services are rendered.

LOCATION 2:

Location Name:	
Please Designate a Two Letter Alphanumeric Code (ex: the first two letters of your location name):	
Location Address:	
Location Phone #	
Location Phone # for Patient Billing Calls	

Is location for:

☐ Inpatient Services Only
☐ Outpatient Services Only
☐ Both Inpatient and Outpatient

Would you like to track both inpatient revenue and outpatient revenue for this location separately? ☐ Yes ☐ No

Default Physician: (if there is only one physician in the group that practices at this location, we can default his name into this location.) If not applicable, leave blank.
Default physician name:
CLIA#:

Statement types to be used: (Place a check next to the type you would like.)	
Family:	
Patient:	

Location of Services Information:

- A location is any hospital, nursing home, or office where services are rendered.

LOCATION 3:

Location Name:	
Please Designate a Two Letter Alphanumeric Code (ex: the first two letters of your location name):	
Location Address:	
Location Phone #	
Location Phone # for Patient Billing Calls	

Is location for:

☐ Inpatient Services Only
☐ Outpatient Services Only
☐ Both Inpatient and Outpatient

Would you like to track both inpatient revenue and outpatient revenue for this location separately? ☐ Yes ☐ No

Default Physician: (if there is only one physician in the group that practices at this location, we can default his name into this location.) If not applicable, leave blank.
Default physician name:
CLIA#:

Statement types to be used: (Place a check next to the type you would like.)	
Family:	
Patient:	

Location of Services Information:

- A location is any hospital, nursing home, or office where services are rendered.

LOCATION 4:

Location Name:	
Please Designate a Two Letter Alphanumeric Code (ex: the first two letters of your location name):	
Location Address:	
Location Phone #	
Location Phone # for Patient Billing Calls	

Is location for:

☐ Inpatient Services Only
☐ Outpatient Services Only
☐ Both Inpatient and Outpatient

Would you like to track both inpatient revenue and outpatient revenue for this location separately? ☐ Yes ☐ No

Default Physician: (if there is only one physician in the group that practices at this location, we can default his name into this location.) If not applicable, leave blank.
Default physician name:
CLIA#:

Statement types to be used: (Place a check next to the type you would like.)	
Family:	
Patient:	

Location of Services Information:

- A location is any hospital, nursing home, or office where services are rendered.

LOCATION 5:

Location Name:	
Please Designate a Two Letter Alphanumeric Code (ex: the first two letters of your location name):	
Location Address:	
Location Phone #	
Location Phone # for Patient Billing Calls	

Is location for:

☐ Inpatient Services Only
☐ Outpatient Services Only
☐ Both Inpatient and Outpatient

Would you like to track both inpatient revenue and outpatient revenue for this location separately? ☐ Yes ☐ No

Default Physician: (if there is only one physician in the group that practices at this location, we can default his name into this location.) If not applicable, leave blank.
Default physician name:
CLIA#:

Statement types to be used: (Place a check next to the type you would like.)	
Family:	
Patient:	

Individual Physician Information

- **Please complete the following for every physician in your group.**

PHYSICIAN #1

Physician Name:
M.D. or D.O. (Circle)

Social Security Number:	- -

Physician's Specialty	
Medicare UPIN#:	

Individual Physician Provider Numbers For Each Location (#1-10):				
Blue Cross/Blue Shield:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Medicaid:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Anthem/Other:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Medicare Pin #:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Worker's Compensation:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Other:				

Individual Physician Information

- **Please complete the following for every physician in your group.**

PHYSICIAN #2

Physician Name:	
	M.D. or D.O. (Circle)

Social Security Number:	- -

Physician's Specialty	
Medicare UPIN#:	

Individual Physician Provider Numbers For Each Location (#1-10):				
Blue Cross/Blue Shield:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Medicaid:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Anthem/Other:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Medicare Pin #:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Worker's Compensation:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Other:				

Individual Physician Information

- **Please complete the following for every physician in your group.**

PHYSICIAN #3

Physician Name:	
	M.D. or D.O. (Circle)

Social Security Number:	- -

Physician's Specialty	
Medicare UPIN#:	

Individual Physician Provider Numbers For Each Location (#1-10):				
Blue Cross/Blue Shield:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Medicaid:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Anthem/Other:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Medicare Pin #:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Worker's Compensation:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Other:				

Individual Physician Information

- **Please complete the following for every physician in your group.**

PHYSICIAN #4

Physician Name:	
	M.D. or D.O. (Circle)

Social Security Number:	- -

Physician's Specialty	
Medicare UPIN#:	

Individual Physician Provider Numbers For Each Location (#1-6):				
Blue Cross/Blue Shield:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Medicaid:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Anthem/Other:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Medicare Pin #:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Worker's Compensation:				
1:	2:	3:	4:	5:
6:	7:	8:	9:	10:
Other:				

Billing Assignment

- indicate below, with a check mark, any insurance carrier for which assignment is accepted for claims.

Blue Cross/Blue Shield _____

Medicare _____

Medicaid _____

Anthem _____

Other : _____ _____

Other : _____ _____

Other : _____ _____

Other : _____ _____

System Operator Information

- Please indicate the full name and four letter/number password for each operator who will be signing on to the system. Please give middle initial.

Name: Password:

Name of principle on-site contact for all correspondence and telephone contacts regarding hardware and software:

Name:

OUTSIDE COLLECTION AGENCY INFORMATION

- Please list all collection agencies you currently use for your practice.

1. Collection Agency Name: _____

2. Address: _____

_____

_____

_____

1. Collection Agency Name: _____

2. Address: _____

_____

_____

_____

HMO AGREEMENTS AND CAPITATION AGREEMENTS

- Please list below any agreements that have special billing requirements.

Name: _____

Address: _____

_____

_____

_____

Billing Specifications: _____

_____

_____

_____

_____

_____

Name: _____

Address: _____

_____

Billing Specifications: _____

_____

REFERRING PHYSICIANS

- If you would like us to build a referring physician database for your practice so you do not have to at the time of billing, please list all of your referring physicians for your practice below along with their Medicaid provider # and their Medicare UPIN #. Referring Physician is required when submitting claims to Medicare and Medicaid.

Physician's Full Name	Medicaid Number	Medicare UPIN Number

ADJUSTMENTS

- list any special adjustment types used by your practice that you would like programmed into the PBM system.

_____

_____

_____

_____

_____

_____

_____

_____

CHARGE MASTER

Please include a complete copy of your charge master (fee schedule for all charges in your practice). NOTE: this information is NOT entered by PBM. We organize the schedule and instruct the client on how it is inputted into the CHARGE MASTER FILE.

CAPITATED AGREEMENTS

Please include a complete copy of all procedures and fees that are capitated. We will show you how to program them into the computer so they automatically pop up when billing for that insurance plan.

EXPLANATION OF SPECIFIC CLAIM

YOUR PRACTICE NAME
STREET ADDRESS
CITY STATE ZIP

DATE:	09/14/987
CONTRACT NUMBER:	
GROUP NUMBER:	
BILLING INQUIRES :	800-321-4321
ATTENDING PHYSICIAN:	John Doe MD
PATIENT:	Jane Doe
NUMBER:	MS0000012-003
DATE OF SERVICE:	7/29/98
BALANCE DUE:	$42.00

PATIENT NAME / MAILING ADDRESS
STREET ADDRESS
CITY STATE ZIP

YOUR PRACTICE NAME
STREET ADDRESS
CITY STATE ZIP

TO INSURE PROPER POSTING TO YOUR ACCOUNT, PLEASE DETACH AND RETURN TOP PORTION WITH PAYMENT

DEAR JANE:

The claim listed above for which you are responsible is now seriously PAST DUE. It is important for you to make payment in full immediately or contact us at once to discuss alternative payment arrangements. As we have stated before, we will be happy to work out a payment plan with you...we cannot help you solve this matter, however, if you do not contact us. We will have no alternative but to consider further collection action on your claim if we do not hear from you...so please call us today.

Thank you,

DATE	CODE	CPT	UNITS	DESCRIPTION		AMOUNT
7/16/98	99212	99212	1	FOCUSED		$42.00
					TOTAL DUE	$42.00