TriMed
BILLING SOLUTIONS

Practice Analysis Form

Download, Save and Email Form to info@trimedbs.com

Practice Name: _____ Specialty:_____

State: _____ Phone: _____ Fax:_____

Contact Name: _____ Email:_____

How many providers in the group? _____ How many clients do you see weekly?_____

Is your current billing done by an: in-house biller ☐ or outsourced (billing service) ☐

If outsourced why the interest in changing? _____

If in-house are you planning to keep your staff?_____

What major problems are you currently facing with your billing structure?_____

_____

What Practice Management System are you currently using?_____

What clearinghouse are you currently using?_____

What amount is outstanding on your AR? 0-90 days_____ over 90 days_____

How often are you submitting claims?_____ Are you doing up front collections?_____

What service are you interested in:

Full Practice ☐ AR Recovery ☐ Claims Submissions ☐ Credentialing ☐

Please fax the completed form to **866-473-0576 or Submit file to trimed09@gmail.com.**
We will contact you within 24 hrs.

866.319.3977 Phone info@trimedbs.com 866.473.0576 Fax