INDIANA UNIVERSITY HEALTH CENTER
BILLING REVIEW REQUEST FORM

NAME: _____ DATE REC'D: _____

ID #: _____ PHONE #: _____

LOCAL ADDRESS: _____ E-MAIL ADDRESS: _____

HAVE YOU EVER RECEIVED A BILL FROM THE HEALTH CENTER? ☐ Yes ☐ No

WAS ALL THE INFORMATION CORRECT ON YOUR BILL? ☐ Yes ☐ No; IF NO, EXPLAIN:

VISIT DATE OF BILL: _____ AMOUNT OF BILL: _____

PLEASE DESCRIBE YOUR REQUEST AND THE REASON YOU BELIEVE IT IS JUSTIFIED:

Use back of page, if necessary.

AUTHORIZATION FOR RELEASE OF INFORMATION

IN ORDER FOR US TO PROPERLY INVESTIGATE YOUR REQUEST, WE WILL NEED YOUR AUTHORIZATION TO REVIEW YOUR HEALTH CENTER MEDICAL RECORD. BY SIGNING BELOW, YOU AUTHORIZE THE RELEASE OF YOUR MEDICAL RECORD – FOR THE DATE(S) OF SERVICE IN QUESTION ONLY – TO BE REVIEWED BY INDIANA UNIVERSITY HEALTH CENTER ADMINISTRATION. ONLY THOSE INDIVIDUALS AUTHORIZED TO APPROVE OR DENY YOUR REQUEST WILL REVIEW YOUR MEDICAL RECORD.

I UNDERSTAND THAT I MAY REVOKE THIS REQUEST AT ANY TIME IN WRITING, EXCEPT TO THE EXTENT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THE REQUEST SHALL REMAIN VALID UNTIL REVOKED OR UPON THE EXPIRATION OF THIRTY (30) DAYS, WHICHEVER OCCURS FIRST.

_____ _____
Patient Signature *Date*

After your request is investigated, you will be contacted by phone or by letter. If we do not reach you within ten (10) working days, please call (812) 855-6511 and inquire about the status of this review.

OFFICE USE ONLY: BATCH # _____ POSTING DATE _____

Revised 8/01