FORM SCOPE
MEDICAL BILLING ANALYSIS

UB-92 AND/OR INFORMATION CONTAINED ON UB-92 RELEASE/AUTHORIZATION FORM

DATE: _____

TO: _____

_____

ATTN.: _____

Please mail to FormScope, Ltd. a copy of the UB-92/UB-04 or information contained on a UB92/UB04 consisting of:

__ **TYPE OF FACILITY**
__ **ADMISSION DATE**
__ **ADMISSION HOUR**
__ **ADMISSION TYPE**
__ **DISCHARGE HOUR**
__ **PATIENT STATUS**
__ **CPT/HCPCS CODES & MODIFIERS**
__ **REVENUE CODES**
__ **REVENUE DESCRIPTION**
__ **ADMITTING DIAGNOSIS**
__ **OTHER DIAGNOSIS CODES**
__ **PRINCIPAL DIAGNOSIS CODE**
__ **DRG/APC APPENDED BY SYSTEM**
__ **ICD-9 PROCEDURE CODES/DATES**

PERTAINING TO HOSPITALIZATION FROM: _____ 20_____ TO _____ 20_____.

I AM WILLING THAT A PHOTOSTAT OF THIS AUTHORIZATION BE ACCEPTED WITH THE SAME AUTHORITY AS THE ORIGINAL.

_____ _____
PATIENT NAME DATE OF BIRTH

_____ _____
PATIENT ACCOUNT NUMBER CITY

_____ _____
ADDRESS STATE/ZIP

_____ _____
SIGNED DATE OF SIGNATURE

By my signature above, I acknowledge the release of any Protected Health Information (PHI) to the individual(s) designated on this release form. This protected health information is to be disclose under this authorization at my request, as permitted by 164.508©(1)(iv) of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). I acknowledge that I have received a copy of this authorization. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for the revocation to the Company. This release will remain in effect and valid for 90 days from date of signature
This includes any future requests for any and all accounts regarding the above patient.