American patients: please fill and submit this 2 page form to AMHA if you wish to have them bill your insurance company on your behalf.

AMHA

AMERICAN MEDICAL HEALTH ALLIANCE

PO Box 2065
Houston, Texas 77252-2065
Office: (281) 820-1900
Fax: (281)453-1945
Toll Free: (800) 785-8765
E-mail: info@amhabilling.com
Web: www.amhabilling.com

NOTICE TO ALL PATIENTS REGARDING MEDICAL INSURANCE

A major concern all patients have is the extent to which their insurance companies will pay for medical services. We are experts in the insurance coordinating field and have been successful in collecting on health claims. Patients can choose from the following two payment options. Please initial the option that best serves you.

*** Option #1** **Billing Fee: $300** ________________

This option offer patient's a flat rate of $300 per service provider (physician / facility) for AMHA to organize, prepare and submit medical claims to their insurance carrier. The flat rate satisfies up to four-weeks of billing for covered services.

*** Option #2** **Contingency Fee: 20%** ________________

Option #2 does not require up-front money, and our service fee is based on gross recovery. This option offers the basic, as described in Option #1, however, this option is turn-key and covers the patient for any insurance follow-up, telephone calls, faxes, resubmissions, correspondence, underpayments, policy plan analysis, and denials.

*Some Restrictions May Apply Please Contact Our Office for More Details

Although there is **NO GUARANTEE** of payment most claims are finalized within 6 to 8 weeks. Within 8 to 10 weeks we should have one of three outcomes: 1) a payment 2) a request for more information 3) a denial. If payment for your claim is denied, we will take the necessary steps to appeal any denials which may include sending letters of appeal to a medical review board, contact the employer, notifying various State Boards of insurance etc., in an effort to reverse the denial.

To authorize our company's involvement in seeking reimbursement for the medical expense you incur at this facility, please do the following:

- Choose from the two payment options from above by initialing on the line.
- Sign and date the authorization at the bottom of this page.
- Complete the form on the opposite side of this page, making sure that all application fields are answered in sections A, B, and C.
- Give all forms to the facility representative at your doctor's office, clinic, or hospital. They will forward them to us. Or you may send the forms directly to us at the address above or fax.

We look forward to assisting you. If you should have any questions, please feel free to call us at (800) 785-8765. For immediate transmission of documents, fax them to (281) 453-1945.

SIGNATURE REQUIRED

I was treated at ____ and I fully understand the above and hereby authorize AMERICAN MEDICAL HEALTH ALLIANCE to file claim(s) to my insurance carrier for expenses incurred at this facility, and to obtain and release any information related to my medical treatment and insurance. By signing this form, I authorize AMERICAN MEDICAL HEALTH ALLIANCE to deposit all monies received on my behalf. I also acknowledge my obligation to pay AMERICAN MEDICAL HEALTH ALLIANCE for their services by selecting one of the two options from above. I am in full understanding that there is NO GUARANTEE OF PAYMENT by using AMERICAN MEDICAL HEALTH ALLIANCE.

____ ____________________

(Signature of Insured or Authorized Representative) (Date)

Do not submit this page to Medicor Cancer Centres.

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SECTION A: PATIENT INFORMATION

Name of Patient ______________________ Patient's SS# ______________

Address ______________ City ______________ State ________ Zip ____________

Home Phone ______________________ Work or Other Phone ______________________

Email ____

Medical Diagnosis ____

Date First Diagnosed for this Condition (M/D/Y) ______________ First Date of Treatment (M/D/Y) ______________

Family Doctor/Referring Physician ____

Patient's Date of Birth ☐☐-☐☐-☐☐☐☐ Patient's Sex Marital Status

Patient Relationship to Policyholder ______________ ☐ Male ☐ Female ☐ Single ☐ Married

☐ Self ☐ Spouse ☐ Child ☐ Other

Person we may contact other than yourself ____

Phone ______________________ Relationship ______________________

Email ____

SECTION B: PRIMARY INSURANCE INFORMATION

Name of Policyholder ______________________ Policyholder's DOB ______________

Name of Insurance Company ____

Address of Insurance Company ____

City ______________ State ________ Zip Code ________ Phone ______________

SS# ______________________ ID# ______________________

Employer Name ______________________ Group # ______________

Name/ext. of insurance contact who has helped you process previous claims ______________

For Champus/Champ VA ONLY: Policyholder's Grade/Rank ______________ Branch of Service ______________

Policyholder's Status: ☐ Active Duty ☐ Retired ☐ Deceased ☐ Champus ID No. ______________

SECTION C: SECONDARY INSURANCE INFORMATION

Group Name / Employer: ______________________ Group # ______________

Name of Policyholder ______________________ Policyholder's DOB ______________

Name of Insurance Company ____

Address of Insurance Company ____

City ______________ State ________ Zip Code ________ Phone ______________

SS# ______________ ID# ______________ Group Name/No. ______________