

FAMILY HEALTHCARE ASSOCIATES
BILLING QUESTION REQUEST FORM

Patient Information:

First Name: _____

Last Name: _____

Date of Birth: _____ Account # _____
(optional)

Insurance Information:

Plan Name: _____

Your Billing Question:

Your Name: _____

Relationship to Patient: _____

How may we reach you with our response?

Home Phone: _____ **Work Phone:** _____

Fax Number: _____ **E-mail Address:** _____

Please fax this request to our Central Billing Office at: 817-459-5263