

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*