

AUDIT AUTHORIZATION

Date _____

Hospital _____ Facility Unit # _____ Dates of Service _____

Patient Name _____ Account # _____

Address _____ City/State _____ Zip _____

Your request to have your bill audited will be forwarded to the revenue integrity department. It is our policy to audit the entire bill whenever a question arises on a *particular* item. Your account will be reviewed for discrepancies resulting in both overcharges and unbilled items. This means, if items are found that were given but inadvertently not charged will be added to your bill and any overcharges will be taken off your bill.

The medical auditors will not address medical necessity for services received. Questions regarding medical necessity should be addressed to your physician.

We will refund or rebill the appropriate person(s) for any discrepancies found. This should clarify questions and/or concerns you have about your bill.

If you do not return this signed consent form within 10 days of this letter, your request for an audit will be disregarded.

I, _____, consent to have the revenue analysis audit my hospital bill and medical record to determine if all charges are correct. I understand that both overcharges and unbilled items will be addressed and the appropriate person(s) may be refunded or rebilled. I understand the amount of my bill may increase or decrease.

Signature of patient _____

Date of signature _____

Note: This form must be signed by the patient or the legally responsible party.

If you have any specific questions regarding particular items on your bill please attach a detailed list to this authorization.

Thank You