



Omni Funding Claims Processing Application

Individual Name: _____
Group/Corporate Name: _____
Complete Address: _____
Phone # _____ Fax # _____
E-mail Address: _____
UPIN # _____ Tax ID # _____
Medicare # _____ BC/BS # _____
Specialty: _____

Type of Services Performed:

_____ Office Visits
_____ Hospital In-Patient
_____ In-House Labs (CLIA # _____)
_____ Diagnostic Tests
_____ Outpatient Hospital/Clinic
_____ Surgical Procedures
_____ Other Explain: _____

Other Service Locations (if applicable) _____

Breakdown of Practice:

% _____ Medicare % _____ Medicaid % _____ Comm. Insurance
% _____ Workers Comp % _____ Private Pay % _____ Other

Number of Managed Care Contracts (Capitation) _____

How is your billing done currently? _____ In-House (# of personnel needed)
_____ Billing Service _____ Global Hospital Contracts _____ Private Mgmt Co.

Are your claims being sent electronically? _____ Medicare _____ Medicaid
_____ Commercial Insurance

Turn-Around Time For Payment: _____ (Days) Medicare _____ (Days) Medicaid
_____ (Days) Commercial Insurance

Avg. Mo. Billings \$ _____ Avg. Mo. Collections \$ _____

Any additional practitioners providing services? (Include Provider #'s

