Fee Analysis Request

Today's date: _____

General Information
Practice Name
Tax ID#:
Contact person's name:
Contact person's phone #:
How do you prefer we send back your prepared fee analysis?
☐ Mail *(please provide address):*
☐ Email *(please provide email address):*
☐ Fax *(please provide fax number):*
Comments:

You may request an analysis for a maximum of 30 codes: **(completion of all fields is required)**

	Charge Code (CPT, HCPCS, Other)	*Modifier*	*Charges ($)*	*If billed other than physician, list degree:*
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Please return completed form to:

THE ALLIANCE
Employers moving health care forward

Attn: Provider Relations
PO Box 44365, Madison, WI 53744
Email: providerservices@the-alliance.org

Phone: 608-276-6620
Fax: 608-276-6626