



BILL REVIEW REQUEST FORM

(Check One)  Bill Review  Re-pricing  Information Only

Please perform Bill Review on the bills provided:  Yes  No

Submission Date: \_\_\_\_\_ If this case is time sensitive, put "return by" date here: \_\_\_\_\_

Claims Representative: \_\_\_\_\_

Company: \_\_\_\_\_ Client Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

TEL: \_\_\_\_\_ FAX: \_\_\_\_\_

E-mail: \_\_\_\_\_

If you are a Law Firm or TPA who is your client: \_\_\_\_\_

Claims Person Name and Title if different from above: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Name of Patient/Claimant : \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

TEL: \_\_\_\_\_

I am interested in the following service:

\_\_\_\_\_ Bill Review & Information Only

\_\_\_\_\_ Information and Negotiation Services (you will need to execute a Customer Agreement & Medical Release form).

Payment will be made as follows:

\_\_\_\_\_ I will mail a check for the full amount to the address below.

\_\_\_\_\_ Please email me a secure link so I may pay by credit card.

**Send the following information (Check List):**

- Completed Review Request Form     Completed Customer Negotiations Agreement
- Itemized Medical and Hospital bills     Executed Medical Information Release Form
- UB92 Claim Form

Once completed a report will be mailed to you in approximately 3-5 business days. Please check below, in *Return Instructions*, how you would like us to report back to you.

**Facts about the case**

Specific complaints by patient: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did injury occur: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If auto accident, please describe the location of the damage of each vehicle and the severity of damage: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you aware of any pre-existing conditions or injuries? If yes, please describe the pre-existing conditions and/or the type of prior injury and the date it occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In as much detail as possible, explain what occurred in the accident. How much time did the patient miss from work? Is the patient still being treated?

\_\_\_\_\_

\_\_\_\_\_

Other notes or Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

**Please note:** Medical providers are not permitted to comment on the reasonableness of the treatment costs. A Bill Review will compare the charges with reasonable and customary allowances in the geographic area where services were rendered, and reduce the bill accordingly.

**Time Frame:** Be advised Bill Reviews can take up to 10 days after we receive the case for analysis. But in most cases they are completed within 3-5 business days.

Send File or Fax to:  
TellLink Health  
9720 Coit Road, Suite 220, #201  
Plano, TX 75025-5833  
888.853.6339 TEL  
888.473.0933 FAX

You can email the information directly to us at [review@tellink.com](mailto:review@tellink.com)

### **Review Return Instructions**

Please return completed review by: *(Check all that apply)*  Mail  Email  Fax

Originals need to be returned *(Please Check one)*: Yes  No

**If you have any questions please call us at (888) 853-6339.**