PLEXUS HEALTH SOLUTIONS, INC.

What is the name of your FQHC?_____

Last years' gross billing $_____

Last years' revenue $_____

Percentage of your practice that is; Medicaid _____%, Medicare _____%, Other _____%

Number of encounters last year_____

Current A/R (both debits and credits) $_____

A/R that is over 120 days old $_____ and _____% over 120 days old

How many DDS's _____ MD/DO's _____ PA's _____ NP's _____ Ph.D.'s _____

Number of above that is full time _____ part time _____

Do you take credit cards or e-checks for patient payments? Yes☐ No ☐

How many locations do you service? _____

How many counties do you service? _____

When was the last time you raised your fees? _____

Do you pre-qualify patients and their insurance coverage? Yes☐ No ☐

Do you perform labs/x-rays on site? Yes☐ No ☐

What specialties do you service?

_____

_____

We won't just change the way you do billing, we'll change the way you do business.

PLEXUS HEALTH SOLUTIONS, INC.

Do you provide non-emergent transportation? Yes☐No ☐

What software system(s) do you use?

_____

_____

Do you use an EMR software? Yes☐No ☐

Do you use an E-Rx software? Yes☐No ☐

Do you perform on-site chart audits? Yes☐No ☐

Would you need our credentialing services? Yes☐No ☐

What are your office hours? _____ a.m. to _____ p.m. M T W Th F Sa Su

Who should we contact in regard to this information?

Phone/email:_____

Today's Date: _____

Please email this completed form to: info@plexushealthsolutions.com
Or fax to: 262-654-9333
Mail to: P.O. Box 0655, Kenosha, WI 53141-0655

We won't just change the way you do billing, we'll change the way you do business.