

INSTRUCTIONS FOR FULLARD REVIEW SUBMISSION

When sending the information from the provider, collection agency or attorney back to us for review; please place the documents in the following order:

1. The Fullard Review Cover Sheet (**one sheet for each bill**). Make copies if you have more than one billing issue.
2. The completed, signed and dated Consent Form – both pages.
3. A brief statement regarding the billing issue
4. A copy of the most recent notice you are receiving from the collection agency or
5. A copy of the letter you are receiving from an attorney demanding payment for a medical bill.
6. A copy of the *actual bill* (showing date(s) of service, procedure codes and billing amounts – itemized) from the provider who rendered the service.
7. THE WHOLE BILL, NOT JUST THE PAYMENT PORTION.
8. DO NOT SUBMIT CREDIT REPORTS OR EXPLANATION OF BENEFITS, THEY WILL BE RETURNED.
9. EACH BILL MUST HAVE IT'S OWN COVERSHEET TO BE LOGGED INTO THE SYSTEM. If you send multiple bills and only 1 cover sheet, they will be returned to you.

Mail the documents to:

OR

Fax the documents to:

FULLARD REVIEW UNIT
MEMBER CORRESPONDENCE
PO BOX 105200
TUCKER GA 300855200

1-866-483-1045

*Please: do **not** mail **and** FAX as this could delay the response time.*



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Name of Individual/Consumer/Patient/Applicant

Date of Birth

IF AVAILABLE:

ID Number Used by
Requesting Agency

ID Number Used by
Releasing Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize:

(Name of Person or Agency Requesting Information)

(Address)

to obtain from:

(Name of Person or Agency Holding the Information)

(Address)

the following type(s) of information from my records (and any specific portion thereof):

for the purpose of:

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

ninety (90) days unless I specify an earlier expiration date here: _____

(Date)

one (1) year.

the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

(Date)

(Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness)

(Title or Relationship
to Individual)

(Signature of Parent or other legally Authorized
Representative, where applicable)

(Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Date this authorization is revoked by Individual)

(Signature of Individual or legally authorized Representative)

FULLARD REVIEW

MEMBER ID #: _____

(This is the 12 digit ID number on the Medicaid or PeachCare for Kids ID card)

MEMBER'S NAME: _____

Fullard Review Cover Sheet

Date of Service: _____

Amount being billed: \$ _____

The Doctor/Facility billing you: _____

NOTE: *Each bill you submit for review must have its own cover sheet
– 1 cover sheet = 1 bill to be reviewed.*

*Please make additional copies of the page for each bill you will submit
BEFORE you enter the Date of service, amount being billed and the
doctor/facility name.*