



Patient Statement Set-Up Sheet

Account Information

Practice Name:		Ingenix User ID:	
Contact Name:			
Address:			
City:	State:	Zip:	
Phone Number:		Fax Number:	
Practice Management System:			
Vendor Name, Contact & Phone Number:			

Standard Information

Credit cards to be shown on Statement:

<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard Standard
<input type="checkbox"/> American Express	<input type="checkbox"/> Discover
<input type="checkbox"/> None	

Approximate Monthly Volume: (Requires 100 document minimum per month. Client will be billed for a minimum of 100 documents per month regardless if less than 100 were generated.)

Email Address for File Receipt, Confirmation and File Processing Report: (list up to two emails)

1. _____
2. _____

Envelope: #10 Outbound with #9 Security Return Envelope

Please fax a sample of your current statement with this set-up sheet to 719-457-8366.

Pricing

Remit address, if different from above:

Address:		
City:	State:	Zip:
Phone Number:		Fax Number:
Base Price/Statement (\$0.67, \$0.18 for each additional page):		
Special Statement Handling:		

As an additional consideration for the terms and conditions of sale by Ingenix to the undersigned, the undersigned agrees to indemnify and hold Ingenix harmless from and against any and all claims, litigation, and damages of every kind and nature, performance, by Ingenix of the services set forth herein for the undersigned, whether said claims, litigation and damages are brought against Ingenix by the undersigned, those claiming by, through or under the undersigned, or by any third party.

It is imperative Ingenix be notified in advance of any change in the physician's office software which could affect the format of the statement. Failure to do so will delay the billing process. This would include software updates.

Customer Signature: _____ **Date:** _____

Ingenix maintains a strict policy of collecting a postage deposit from all customers utilizing the statement processing and production service. This deposit is based on an estimate of your usage during a one (1) month period and will be credited to your account until termination of the service, whereupon it will be fully refunded, less any unpaid charges for services rendered. Please make deposit check payable to "Ingenix".

Monthly Patient Statement Volume _____ x \$0.67 rate + Deposit Amount \$ _____.

Please specify payment method for postage deposit required to start account.

e-Check: Routing # _____ Account # _____
 Credit Card: Type: _____ Account # _____ Security Code: _____ Expiration Date: _____

Return this completed sheet with postage deposit and sample statement to:

Ingenix Sales Department, 1755 Telstar Drive, Suite 400, Colorado Springs, CO 80920