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MED FIRST
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Phone: 609-654-6525
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Facility Reimbursement Analysis

Your Surgery Center Information:

Name: ____

Address: ____

Contact: ____

Phone: ___________________

Email: ___________________

1.) Payor Mix – Please provide % of patients for each insurance (based on past two years revenue)

Medicare	%
Aetna	%
BC/BS	%
Cigna	%
United HC	%
Oxford	%
	%
	%

2.) Reimbursement Rates – please provide current contracted reimbursement rates:

	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Default
Aetna	$	$	$	$	$	$	$	$	$	$
BC / BS	$	$	$	$	$	$	$	$	$	$
CIGNA	$	$	$	$	$	$	$	$	$	$
UHC	$	$	$	$	$	$	$	$	$	$
Oxford	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$
	$	$	$	$	$	$	$	$	$	$

Fax completed form to (609) 981-9087

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