Request for Billing Information

This form will allow me to request access to my billing information that Accredo maintains.

PLEASE PRINT CLEARLY

1. Verification

Individual for whom records are being requested:

First Name: ____

Middle Name/Initial: ____

Last Name: ____

Date of Birth: _____/____/_____

Address on Record:

Street: ______________________________Apt/Suite #__________ City: _______________________

State: ________ Zip: _____

Phone number on record: (______) _________ - _________

Request made by: ____

Relationship (Self, Personal Representative): ____

Preferred Phone number where we can reach you if we need to contact you to process your request _________________

2. Request

Information Requested:

☒ Patient Billing Records

Requested Date Range: Start Date: _____/____/_____ End Date: _____/____/_____

3. Completed Records

Requested Format:

☐ Email: _______________________________ Confirm Email: _________________________________

☐ Mailing Name/Address: ____

Street: ______________________________Apt/Suite #__________ City: _______________________

State: ________ Zip: _____

☐ Fax: (______) _________ - _________

Billing Information is readily available for the previous ten years.

Please return completed form to: Email: AccredoHIPAARequests@express-scripts.com

Accredo Health Group, Inc.
3000 Ericsson Drive, Suite 100
Warrendale, PA 15086
ATTN: Accredo HIPAA Request

FAX: 866-495-6519