accredo®

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