FNA, P.C.
Billing Information Request Form

Section A: Individual to complete and sign. (Please Print)

I am submitting this request to receive a copy my or my child's billing information created by FNA, PC. I will receive the requested billing records within 30 days of my submitted request. FNA, PC may extend this deadline by 30-days provided that I receive written notification of this extension.

1. Please complete the information below.

Patient Name: _____
Last First Middle

Telephone #: _____ Patient's Date of Birth: _____

2. Please check the box indicating how would you like to receive the requested billing information?

☐ Mail to my current address: _____
Street Address City State Zip Code

☐ Fax to this fax number: _____

☐ Pick-up (you will be required to provide photo identification.) Please provide a phone number where we may contact you when copies are ready for pick up._____

3. Please complete the following and include the Date(s) of Services for the records being requested.

❒ Billing Statement
❒ Other Billing Information, describe: _____

Please provide the Date(s) of Service you would like records for: _____

_____ _____
Signature of Patient or Patient's Personal Representative Date

_____ _____
Print Name of Patient's Personal Representative (if applicable) Personal Representative's Relationship to Patient (if applicable)

4. Mail the completed form to:

MCAP
2730-B Prosperity Avenue
Fairfax, VA 22031

OR

Fax the completed to: 703.289.1414

If you have any questions regarding your billing records, please call the MCAP Billing Office at 703.289.1400.

Section B: For office use only

_____(Name) Records mailed/picked-up/faxed on _____ (date)

_____(Name) Sent notice of 30-day extension on _____ (date)
(if applicable)

_____(Name) Request denied on _____ (date)
(if applicable)

Reason for denial_____
(if applicable)