Consulting Service Request Form

Contact Information

Name:

Title/Position:

Organization:

Email:

Phone:

Website (optional):

Consulting Services Requested (Please select the services you are requesting. You may choose more than one option.)

_____ **Coding and Compliance Auditing** (please provide any additional details)

_____ **HIM/Medical Records Operations Management** (please provide any additional details)

_____ **Medical Staff Credentialing** (please provide any additional details)

_____ **Physician Practice Management** (please provide any additional details)

_____ **Medical Coding and Billing Services** (please provide any additional details)

_____ **Clinical Documentation Improvement Audits and Education** (please provide any additional details)

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_____ **Other Revenue Cycle Management Related Services** (please provide any additional details)

Additional Information

Current Challenges: (Please describe any specific challenges your organization is facing that you hope to address through consulting services.)

Budget Constraints: (If applicable, please provide information on your budget for this project.)

Other Relevant Information: (Any additional details you think we should know to better serve you.)

Preferred Contact Method

_____ **Email** _____ **Phone** _ ____**Online/Virtual**

_____**In-Person Meeting**

Preferred Contact Time

_____ **Morning** _____ **Afternoon** _____ **Evening**

Confidentiality and Privacy Concerns

Are there any confidentiality or privacy concerns we should be aware of?

Preferred Outcomes and Measures of Success

What specific outcomes do you hope to achieve with our consulting services?

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How will you measure the success of this project?

References or Supporting Documents

Please attach any relevant documents or references that can help us understand your needs better:

Acknowledgment

By submitting this form, you agree to be contacted by Trifecta Revenue Solutions, LLC for further discussion of your consulting needs.

Signature:

Date: