**Letter of Authorization to Bill**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acuity Hospital of Houston requests that

(patient name)

have the following

(test / procedure)

completed at

(facility)

on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (date) (time)

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has ordered the above procedure for this patient. It is our understanding that this is an outpatient procedure and the patient is not being transferred to your facility for inpatient admission.

Please ensure the patient is transferred back to Acuity Hospital via ambulance \_\_\_\_\_\_\_\_\_\_\_\_\_

 (company name)

* Authorization has been given for you to bill the above procedure to Acuity Hospital of Houston for services required. **Additional procedures or tests will not be the responsibility of Acuity Hospital.**
* An authorization number has been obtained for your billing to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (insurance company name)

Please forward all test results, operative reports, or other documentation regarding treatment and care of the above mentioned patient to Acuity Hospital of Houston, 2001 Hermann Drive Houston, Texas 77004. **Fax- 281.921.5350**

Attention: Medical Records

**Please forward your invoice with a copy of this document to:**

* **Acuity Hospital of Houston**

2001 Hermann Drive

Houston Texas 77004

Attn: Accounts Payable

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Director of Case Management