



Request for Billing Information

This form will allow me to request access to my billing information that Hillside 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: PharmacyDirector@hillsidespecialty.com](mailto:PharmacyDirector@hillsidespecialty.com)

Hillside Specialty Pharmacy 250 Fame Ave, Ste # 105,
Hanover, PA 17331 Phone No. 717-417-8355 Fax No. 717-447-0595