



**STRATEGIC  
HEALTH DEVELOPMENT  
CORPORATION**

9501 NE 2<sup>ND</sup> Avenue  
Miami Shores, Florida 33138  
Phone: 800/874-2378  
Fax: 305/455-2172

**AUDIT REQUEST FORM**

SHDC CLIENT NAME:  
CONTACT NAME:  
TPA NAME:  
PLAN YEAR:  
CARRIER NAME:  
CONTRACT YEAR:  
PHONE NUMBER:

\*\*\*\*\*

CLAIMANT NAME:

FIDUCIARY (Employer Group):

PROVIDER/FACILITY:

Total Amount of Bill: \_\_\_\_\_ Dates of Service: \_\_\_\_\_

PPO: \_\_\_\_\_ PPO Discount: \_\_\_\_\_

Please check one: ERISA \_\_\_\_\_ Non – ERISA \_\_\_\_\_

**Type of Review to be performed:**

**Fees:**

- ( ) Reasonable & Customary benchmarking review 25% of savings
- ( ) Billing Error review only 20% of savings
- ( ) Complete Medical Record review 30% of savings
- ( ) Upfront Negotiation / Sign-off R&C benchmarking 30% of savings
- ( ) Upfront Negotiation / Sign-off Billing Error review 25% of savings
- ( ) Upfront Negotiation / Sign-off Complete Med. Rec. 35% of savings

SPECIAL INSTRUCTIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I agree, on behalf of the above referenced client, to pay the above percentage of savings as fees to SHDC for the completed audit. Payment of the fee to SHDC is due on or before 30 days following the completion of the audit. I further agree that any and all legal fees, cost, expenses and damages in the event of any claim or suit that arises from the audit and this agreement shall be the sole responsibility of the above named client.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)