Billing Change Request Form

One (1) form per patient per date of service

Fax completed form to **844-405-9081**

Section 1: Requestor Information

Date of Service: _____ Accession #: _____

Facility Name/Number: 10-_____ Name of Person Requesting Change: _____

Section 2: Patient Demographics

Patient Full Name: _____ Patient Date of Birth: _____

Patient Address: _____

Patient Phone#: _____

Section 3: Test Selection

□ All Tests

□ Specify tests: _____

Section 4: Type of Change

□ INSURANCE UPDATE (complete **Section 5** only) □ DIAGNOSIS UPDATE (complete **Section 6** only)

□ BILL CHANGE (select one below)

- □ Bill Labs to Facility or Clinic (if patient is Skilled/ESRD/Hospice) (**Sections 1, 2, 3** must be completed)
- □ Bill Labs to Patient (**Section 2** must be completed)
- □ Bill Labs to Patient Insurance (complete **Sections 5 and 6**)

Section 5: Patient Insurance - *copy front and back of card and attach OR complete ALL information below.*

Insurance Name and Address: _____

Group Number: _____ Subscriber ID Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Relationship: _____

Guarantor (**if patient is minor**): _____Guarantor Date of Birth: _____

Section 6: Patient Diagnosis Codes

Diagnosis codes (ICD 10 codes only) must be provided in the form of an official order, signed progress note, or signed office visit note. Please attach. All other forms of submission of diagnosis code corrections/updates will NOT be accepted. Descriptions without the ICD-10 codes will NOT be accepted.

This request will only be requested if within 60 days of the date of service to ensure timely filing requirements are met.