HEALTHLAB

HealthLab
25 North Winfield Road
Winfield, Illinois 60190
Phone: 630.933.2633
Fax: 630.933.5292

TO: _____

FAX: _____ **PHONE**: _____

DATE: _____ **RE:** Missing Billing Information

FROM: _____ **# PAGES:** _____

FAX: _____ **PHONE**: _____

Upon review of the test requisition for this patient, the following information is incomplete.

***Please complete and fax to* 630.933.2620.**

PATIENT NAME: _____

DATE OF BIRTH: _____ **DATE OF SERVICE:** _____

☐ **PATIENT ADDRESS:**

☐ **PATIENT INSURANCE INFORMATION:**

MEDICARE NUMBER: _____ Marital Status: _____

For secondary insurance, fax copy of card, front & back or complete below.

INSURANCE: _____

POLICY HOLDER: _____ RELATIONSHIP: _____

GROUP NUMBER: _____ ID NUMBER: _____

INSURANCE CO. ADDRESS:

☐ **DIAGNOSIS** (REQUIRED FOR EACH TEST ORDERED)**:** _____

_____

Physician signature required for DX changes/additions: _____

☐ **The following test(s)/diagnosis code(s) do not meet medical necessity as submitted.**

Please review the patient's chart to see if an additional ICD-9 code(s) or narrative diagnoses are available and applicable or fax a properly executed ABN.

TEST: _____ DX: _____

TEST: _____ DX: _____

TEST: _____ DX: _____

If, upon further review, tests are still not deemed medically necessary, please note: Your account will be billed and you will be responsible for payment of services rendered.

☐☐☐ WARNING ☐☐☐