Dear Client

Thank you for choosing HealthLab for your laboratory needs.

This *Client Billing Packet* has been developed to assist you in working with us on your billing needs. Included is helpful information about the patients billed through your client account but also for patients who are billed directly through their insurance carrier.

Your lab client billing representative will be contacting you soon to review this information and introduce himself/herself to you. She/he will also review the contents of this packet and answer any questions you may have.

We look forward to speaking with you. It is our goal to develop and maintain a successful working relationship.

Cindy Ferrari-Smith
Lab Registration and Billing Manager, HealthLab

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Contact Information

MAILING ADDRESS:

HealthLab
Department 4065
Carol Stream, Illinois 60122

WEBSITE:

healthlabtesting.com

PHONE NUMBER:

630.933.6657

FAX NUMBER:

630.933.2620

PHONE HOURS:

Monday - Friday 9:00 am - 4:00 pm

BILLING CONTACTS:

Michele Oyos
Lab Client Billing Representative
630.933.3238
Michele.Oyos @cadencehealth.org

Natalie Craig
Lab Client Billing Representative
630.333.2634
Natalie.Craig@cadencehealth.org

Armanda Taylor
Lab Client Billing Representative
630.933.2693
Armanda.Taylor@cadencehealth.org

Darcy Recchia
Lab Client Billing Representative
630.933.2691
Darcy.Recchia @cadencehealth.org

Mary Lou Wecker
Lab Client Supervisor
630.933.6410
MaryLou.Wecker@cadencehealth.org

If you have any questions not related to billing, please contact your service or sales representative.

Frequently Asked Questions

Q: When will I receive my invoice?
A: You will receive an invoice in the mail about the 15th of each month. It will be sent to the address your office provided to your sales representative.

Q: How do I read my invoice?
A: Please refer to the *How to Read Your Invoice* document included in this packet.

Q: I have a discrepancy on my invoice. How do I request invoice changes?
A: If there is a pricing issue, please contact your sales or service representative. Otherwise, submit a *billing change request form* specifying the tests to be credited or posted to your invoice and the reason for the request. A copy of this form and instructions for completing the form are included in this packet.

Q: What are examples of typical invoice discrepancies requiring a change form?
A: Examples include: Patient needs to have any or all services billed to his/her insurance by HealthLab, your office has billed insurance and so has HealthLab, etc.

Q: How do I make a diagnosis change to a patient account?
A: Submit a *diagnosis change request form*. A copy of this form and how to fill it out are in this packet.

Q: Who do I send the Billing Change Request Form to?
A: Fax it to your lab client billing representative at 630.933.2620.

Q: How can I pay my invoice?
A: You can:

- Mail a check to HealthLab, Department 4065, Carol Stream, Illinois 60122
- Pay via credit card (Visa, MasterCard, Discover or American Express) by filling out the credit card form at the top of the invoice
- Call your lab client billing representative with your credit card information and she/he will process payment

Q: I have other questions not addressed here. Who can I call?
A: For billing questions, contact your lab client billing representative. If you have any other questions, please contact your service or sales representative.

How to Complete a Billing Change Request Form

Described below are the steps for completing a billing change request form.

When changing the billing type from **insurance bill to client bill,** please fill in the following areas of the billing change form:

- Client name and client account number
- Patient name and patient date of birth
- Date of service
- Check *client bill* box in the section called *change billing to* indicating which test(s) you are requesting be changed. If you are requesting that all tests be billed to your client account, please check the box for all tests. It's easier than writing out each separate test to be changed, which saves time.
- Fill in the reason for the change request (e.g., you billed the patient's insurance, the patient's tests were ordered as insurance bill in error, etc). By law, HealthLab must bill ALL Medicare and Medicaid patients because we are the lab performing the testing.
- Print the name of the person completing the form in the *form completed by* section and include a phone number where the person can be reached in case we have a question regarding the contents of the request form.

When changing the billing type from **client bill to insurance bill**, please fill in the following areas of the billing change form:

- Client name and client account number
- Patient name and patient address
- Patient date of birth
- Date of service
- Patient phone number
- Check *insurance bill* box in the section called *change billing to* indicating which test(s) you are requesting be changed. If you are requesting that all tests be billed to insurance, please check the box for *all tests* (including pathology). If you want all tests except pathology, check the All Tests Except Pathology box. It is easier than writing out each separate test to be changed which saves time.
- Complete the *insurance billing* section with all of the information needed for a claim to be billed. Be sure to include medically necessary diagnoses for all tests.
- Print the name of the person completing the form in the *form completed by* section and include a phone number where the person can be reached in case we have a question regarding the contents of the request form.

Additional copies of the adjustment form can be found on the home page of healthlabtesting.com under lab tests and instructions.

HealthLab
25 North Winfield Road
Winfield, Illinois 60190
Phone: 630.933.2633
Fax: 630.933.2620

HEALTHLAB

Billing Change Request Form

Client Name: _____ Client Account Number: _____

To change the billing type, complete the information below and fax this form to 630.933.2620.

Patient Name: _____ Patient Address: _____

Date of Birth: _____ _____

Date of Service: _____ _____

Patient Phone Number: _____

Change Billing To: ☐ Insurance Bill

☐ Client Bill (Reason): _____

☐ All Tests (Including Pathology) ☐ All Tests (Except Pathology)

☐ Only these charges: _____

For insurance billing, please provide the information below:

Insurance Name: _____ Claim Address: _____

ID#: _____ _____

Group#: _____ _____

Diagnosis: _____

Form completed by:
(please print) _____ Phone Number: _____

Timely Filing Limits

Medicare	12 months
Medicaid	180 days
Blue Cross/Blue Shield (BCBS)	12 months
Aetna	90 days
PHCS/Multiplan	120 days
DuPage Medical Group (DMG)	90 days
United HealthCare	90 days
Cigna, HFN	120 days
Unicare	180 days
Humana	90 days

All other payers not listed here would have a 90 day timely filling limit. In order for us to bill your accounts to the insurance companies, we need your request 21 days before the timely filing limits.

Additional copies of this adjustment form can be found on the home page of healthlabtesting.com under lab tests and instructions.

How to Complete a Diagnostic Change Request Form

This document has two copies of the diagnosis change form on one page. You can use one form for two patients.

There are three reasons to use this form:

1. Removing a diagnosis code from an order
2. Replacing one or more diagnosis codes with other diagnosis codes
3. Switching the order of the diagnosis codes from the ones originally submitted on the order

For *remove DXC(s)/replace with DXC(s),* this section is used for:

- Removing a diagnosis code completely from the order
- Removing a diagnosis code from the order because it will be replaced with another diagnosis code

For *switching order of existing DX(s)* codes, this section is used for:

- Changing the sequence of the diagnosis codes previously submitted on the original order

Once a claim has been submitted to Medicare, we cannot change a diagnosis unless we receive a letter from the physician indicating there was a diagnosis error on his or her part. The physician's signature must be on the letter request along with a corrected order showing the change in diagnosis.

Additional copies of the adjustment form can be found on the home page of healthlabtesting.com under lab tests and instructions.

HealthLab
25 North Winfield Road
Winfield, Illinois 60190
Phone: 630.933.2633
Fax: 630.933.2620

HEALTHLAB

Diagnostic Change Request Form

Client Name: _____ Client Account Number: _____

If a diagnosis code needs to be changed on an order, complete the information below and fax this form to 630.933.2620. All diagnosis changes require a physician's signature.

Patient Name:_____ Date of Birth:_____

Date of Service:_____

- Remove DX(s):_____
- Replace with DX(s):_____
- Switch order of existing DX(s): 1st_____ 2nd_____
  3rd_____ 4th_____

Physician's signature:_____

Form completed by: _____Phone#_____

Diagnosis Change Request Form

Client Name: _____ Client Account Number: _____

If a diagnosis code needs to be changed on an order, complete the information below and fax this form to 630.933.2620. All diagnosis changes require a physician's signature.

Patient Name:_____ Date of Birth:_____

Date of Service:_____

- Remove DX(s):_____
- Replace with DX(s):_____
- Switch order of existing DX(s): 1st_____ 2nd_____
  3rd_____ 4th_____

Physician's signature:_____

Form completed by:_____Phone#_____
Additional copies of this request form can be found on the home page of healthlabtesting.com under lab tests and instructions.

Frequent Billing Issues and Caveats

In an effort to support you in maintaining an efficient billing operation, described below are some of the past issues that we have experienced. Your lab client representative will call you to review these items with you.

1. Incomplete and or no ABN form
2. Incomplete adjustment form
3. Incomplete information on lab orders
4. Change requests outside insurance filing limits

How to Complete and Administer an ABN Form

All providers MUST administer this form for all tests where Medicare payment is likely to be denied. When completing this form, you MUST complete the following sections in order for the ABN to be valid"

- **A-Notifier:**
  This is the name of the entity ordering the service
- **B-Patient name:**
  The first and last name of the beneficiary receiving the notice
- **C-Identification number:**
  This field is optional but the notifier may enter an identification number for the beneficiary
- **D-Items or services believed noncovered:**
  This section is used to list the services believed to be noncovered
- **E-Reason Medicare may not pay:**
  This section must include a reason in friendly language why the items in Section D may not be covered by Medicare
- **F-Estimated cost:**
  The estimated cost for this service
- **G-Options:**
  The patient must choose one option; if option 3 is chosen, the service must not be performed because the patient is stating they do not want the service and are not responsible for payment
- **H-Additional information:**
  Not required
- **I-Signature:**
  Beneficiary or representative must sign the notice indicating he or she has received the notice and understands its contents
- **J-Date:**
  The date the ABN is signed

*Additional information regarding this Medicare document can be found at www.hhs.gov

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

HEALTHLAB

Advance Beneficiary Notice of Noncoverage (ABN)

A. Notifier: _____

B. Patient Name: _____ **C. Identification Number:** _____

Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **800.MEDICARE** (800.633.4227/**TTY:** 877.486.2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Form Instructions

Advance Beneficiary Notice of Noncoverage (ABN)
OMB Approval Number: 0938-0566

OVERVIEW

The ABN is a notice given to beneficiaries in original medicare to convey that Medicare is not likely to provide coverage in a specific case. "Notifiers" include physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories), as well as hospice providers and religious non-medical healthcare institutions (RNHCIs) paid exclusively under Part A. They must complete the ABN as described below and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice. (Note that although Medicare inpatient hospitals and home health agencies [HHAs] use other approved notices for this purpose, skilled nursing facilities [SNFs] must use the revised ABN for Part B items and services.) Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid and notifiers must begin using the revised ABN (CMS-R-131).

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain the original notice on file.

ABN CHANGES

The ABN is a formal information collection subject to approval by the Executive Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA). As part of this process, the notice is subject to public comment and reapproval every three years. The revised ABN included in this package incorporates: suggestions for changes made by notifiers over the past three years of use, refinements made to similar liability notices in the same period based on consumer testing and other means, as well as related Medicare policy changes and clarifications occurring in the same interval. We have made additional changes based on suggestions received during the recent public comment period.

This version of the ABN continues to combine the general ABN (ABN-G) and the laboratory ABN (ABN-L) into a single notice, with an identical OMB form number. As combined, however, the new notice will capture the overall improvements incorporated into the revised ABN while still permitting preprinting of the lab-specific key information and denial reasons used in the current ABN-L.

Also, note that while previously the ABN was only required for denial reasons recognized under section 1879 of the act, the revised version of the ABN may also be used to provide voluntary notification of financial liability. Thus, this version of the ABN should eliminate any widespread need for the notice of exclusion from medicare benefits (NEMB) in voluntary notification situations.

Instructions for completion of the form are set forth below. Once the new ABN approval process is completed, CMS will issue detailed instructions on the use of the ABN in its online Medicare Claims Processing Manual, Publication 100-04, Chapter 30, §50. Related policy on billing and coding of claims, as well as coverage determinations, is found elsewhere in the CMS manual system or website (cms.hhs.gov).

COMPLETING THE NOTICE

OMB-approved ABNs are placed on the CMS website at: http://www.cms.gov/BNI. Notices placed on this site can be downloaded and should be used as is, as the ABN is a standardized OMB-approved notice. However, some allowance for customization of format is allowed as mentioned for those choosing to integrate the ABN into other automated business processes. In addition to the generic ABN, CMS also will provide alternate versions, including a version illustrating laboratory-specific use of the notice.

ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used.

Sections and Blanks:

There are 10 blanks for completion in this notice, labeled from (A) through (J), with accompanying instructions for each blank below. We recommend that the labels for the blanks be removed before use. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or handwritten, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10-point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The option box, blank (G), must be completed by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

A. HEADER

Blanks A-C, the header of the notice, must be completed by the notifier prior to delivering the ABN.

Blank (A) Notifier(s): Notifiers must place their name, address and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier's logo at the top of the notice by typing, handwriting, preprinting, using a label or other means.

If the billing and notifying entities are not the same, the name of more than one entity may be given in the header as long as it is specified in the Additional information (H) section who should be contacted for questions.

Blank (B) Patient Name: Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary's Medicare (HICN) card. The ABN will not be invalidated by a misspelling or missing initial as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.

Blank (C) Identification Number: Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may be used. Medicare numbers (HICNs) or Social Security numbers must not appear on the notice.

B. BODY

Blank (D): The following descriptors may be used in the header of blank (D):

- Item
- Service
- Laboratory test
- Test
- Procedure
- Care
- Equipment

- The notifier must list the specific items or services believed to be noncovered under the header of blank (D).
- In the case of partial denials, notifiers must list in blank (D) the excess component(s) of the item or service for which denial is expected.
- For repetitive or continuous noncovered care, notifiers must specify the frequency and/or duration of the item or service. See §50.14.3 for additional information.
- General descriptions of specifically grouped supplies are permitted. For example, "wound care supplies" would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required.
- When a reduction in service occurs, notifiers must provide enough additional information so that the beneficiary understands the nature of the reduction. For example, entering "wound care supplies decreased from weekly to monthly" would be appropriate to describe a decrease in frequency for this category of "supplies"; just writing "wound care supplies decreased" is insufficient.

Blank (E) Reason Medicare May Not Pay: In this blank, notifiers must explain, in beneficiary friendly language, why they believe the items or services described in blank (D) may not be covered by Medicare. Three commonly used reasons for noncoverage are:

- "Medicare does not pay for this test for your condition."
- "Medicare does not pay for this test as often as this (denied as too frequent)."
- "Medicare does not pay for experimental or research use tests."

To be a valid ABN, there must be at least one reason applicable to each item or service listed in Blank (D). The same reason for noncoverage may be applied to multiple items in Blank (D).

Blank (F) Estimated Cost: Notifiers must complete blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially noncovered services.

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed in blank (D). In general, we would expect that the estimate should be within $100 or 25 percent of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Thus, examples of acceptable estimates would include, but not be limited to, the following:

For a service that costs $250:
- Any dollar estimate equal to or greater than $150
- Between $150-$300
- No more than $500

For a service that costs $500:
- Any dollar estimate equal to or greater than $375
- Between $400-$600
- No more than $700

Multiple items or services that are routinely grouped can be bundled into a single-cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). Average daily cost estimates are also permissible for long-term or complex projections. As noted above, providers may also preprint a menu of items or services in Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

CMS will work with its contractors to ensure consistency when evaluating cost estimates and determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

C. OPTIONS

Blank (G) Options: Blank (G) contains the following three options:

☐ **Option 1.** I want the (D)_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed. *See Ch. 30, §50.14.1 of the online Medicare Claims Processing Manual for instructions on the notifier's obligation to bill Medicare.*

Note: Beneficiaries who need to obtain an official Medicare decision in order to file a claim with a secondary insurance should choose Option 1.

☐ **Option 2.** I want the (D) _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

This option allows the beneficiary to receive the noncovered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

☐ **Option 3.** I don't want the (D) _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided and thus, there are no appeal rights associated with this option.

The beneficiary or his or her representative must choose only one of the three options listed in blank (G). Under no circumstances can the notifier decide for the beneficiary which of the three check boxes to select. Preselection of an option by the notifier invalidates the notice. However, at the beneficiary's request, notifiers may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.

If there are multiple items or services listed in blank (D) and the beneficiary wants to receive some, but not all, of the items or services, the notifier can accommodate this request by using more than one ABN. The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: "beneficiary refused to choose an option."

D. ADDITIONAL INFORMATION

Blank (H) Additional Information: Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. For example, notifiers may use this space to include:

- A statement advising the beneficiary to notify his or her provider about certain tests that were ordered, but not received;
- Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable;
- An additional dated witness signature; or
- Other necessary annotations.

Annotations will be assumed to have been made on the same date as that appearing in blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations.

E. SIGNATURE BOX

Once the beneficiary reviews and understands the information contained in the ABN, the signature box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice.

Blank (I) Signature: The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out "representative" in parentheses after his or her signature. The representative's name should be clearly legible or noted in print.

Blank (J) Date: The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.

Disclosure Statement: The disclosure statement in the footer of the notice is required to be included on the document.

How to Read Your Invoice

The invoice has been divided into three sections

- The top portion provides a summary of the charges, payments and adjustments posted to your account
- The middle portion provides a statement of transactions for the current month
- The bottom portion provides a summary of the balances on the account

1. TOP PORTION OF INVOICE:

- **Statement date**
  This is the date that we closed the invoice in our system; any transactions after this date will be posted on the next invoice
- **Client #**
  Your client account number
- **Invoice #**
  The invoice number for the current monthly transactions
- **Current Statement Total**
  The total amount of charges for this invoice
- *Previous Balance*
  The total balance of previously unpaid invoices before this current invoice closed
- **Pay this amount**
  The total amount due on your account including the current invoice total plus any previous balances owed
- **Payment amount**
  The amount due on your account. If you are paying more than the current invoice amount, please note the invoice numbers and the dollar amounts for each invoice that you are paying so that the payments may be properly credited to your account

2. MIDDLE PORTION OF INVOICE:

We have created a sample of what an invoice might look like with sample items below. Looking under the statement section under the *description of transaction*, below is a description of each item.

- **Prev bal inv 437**
  This is the unpaid balance due on this invoice
- **TEST, BREE Adj-Bill insurance/patient**
  This adjustment appears below prev bal inv 437. This is an adjustment posted for this patient and date of service to this specific invoice.
- **Client payment - Thank You**
  This is a payment received within the current month's invoice that was applied to inv 437
- **Trnsfrd cr fr another inv/acct**
  Since there was a credit of $500 (overpayment) on invoice 453, this amount was transferred FROM that invoice to invoice 437. You will note this transaction as a credit of $500 and the debit (charge) is noted on invoice 453 as a trnsfr cr TO another inv/acct.
- **New balance invoice 437**
  This is the new balance on this invoice at the end of this month's invoice. As long as there continues to be a balance on this invoice, it will continue to print on your invoices until the balance of an invoice is zero.
- Once all previous invoices and transactions against them are noted, the current charges for the invoice will be listed in date of service order. You have the option to have the invoice list patients in alphabetical order. If you prefer that option, please contact your lab client billing representative.
- **Patient Smith, Mary F-07/01/60**
  This is the first patient on your current invoice. The date next to her name is her date of birth. Listing the patient's date of birth is also an invoice option. If you'd like to have this printed next to each patient, please contact your lab client billing representative.
- **The date of service** for this patient's charges is listed under service column
- **The Acct. Transaction** is the test code that was billed
- **The Description of Transaction** is the test name
- **The Patient ID** refers to the patient's identification number in our system
- **The CPT** column is the code that you will bill to the insurance. When there is no CPT noted, it indicates this is an orderable code or panel that carries the special price in our system. In this patient example, a Type/RH/Screen was ordered and the special price for this test is $520.10. However, the CPT codes that you will bill to insurance are 86900, 86901 and 86850. Notice that those tests do not carry any prices.
- **The quantity** column notes the quantity you will bill the insurance for that specific CPT code
- **The Credits** column shows all credits (payments and adjustments) posted to current and past invoices
- **The Charges** column shows all debits (charges and debit adjustments) posted to current and past invoices

3. BOTTOM PORTION OF INVOICE:

- **Current, 31-50....TOTAL**
  The age of the accounts receivable balances that correspond to that age of receivables as of this invoice. There may have been payments or adjustments that may not be reflected until next month's invoice. If you're concerned about the balances being incorrect, please contact your lab client billing representative.
- **Charges This Statement**
  The total current charges
- **Previous balance**
  The previous balance on all unpaid invoices as of this invoice
- **Payments/Adjustments**
  The payments and adjustments posted to your account during this month's current invoice time period
- **Total Amount due**
  The total amount due on your account, including any previous unpaid balances

Sample Invoice

HealthLab
Department 4065
Carol Stream, IL 60122

ADDRESS SERVICE REQUESTED
Due upon receipt

TEST SOURCE FACILITY

25 N WINFIELD RD
WINFIELD, IL 60190

CHECK CARD USING FOR PAYMENT

☐ Mastercard ☐ Discover VISA ☐ Visa ☐ AMEX

CARD NUMBER	
SIGNATURE	EXP. DATE

STATEMENT DATE	CLIENT #	INVOICE#	CURRENT STATEMENT TOTAL
04/07/2011	20000	637	494.21

PREVIOUS BALANCE	* PAY THIS AMOUNT	PAYMENT AMOUNT
15,291.67	211.24	

HealthLab
Department 4065
Carol Stream, IL 60122

Please detach and return top portion with your payment

STATEMENT

Statement of Transactions for: Invoice# 637

Service	Acct. Transaction	Description of Transaction	Patient ID	CPT	Qty	Credits	Charges
		PREV BAL INV 437					12,074.64
		TEST, BREE - 07/07/84					
04/07/11	88002	ADJ-BILL INSURANCE/PATIENT				-5.80	
		CLIENT PAYMENT-THANK YOU					
04/07/11	98888	CLIENT PAYMENT-THANK YOU				-11,568.84	
04/07/11	88010	TRNSFRD CR FR ANOTHR INV/ACC				-500.00	
		NEW BALANCE INVOICE 437					0.00
		PREV BAL INV 453					3,217.03
		CLIENT PAYMENT-THANK YOU					
04/07/11	98888	CLIENT PAYMENT-THANK YOU				-4,000.00	
04/07/11	88009	TRNSFR CR TO ANOTHR INV/ACCT					500.00
		NEW BALANCE INVOICE 453				-282.97	0.00
	R11012345	**SMITH, MARY F - 07/01/60**	A7111101111				
04/01/11	2120161	UREA, 24HR BODY FLUID		84540	1		10.90
04/01/11	2171300	TYPE/RH/SCREEN (PRENATAL)		00000	1		20.10
04/01/11	2173111	86900 BLOOD TYPING ABO		86900	1		
04/01/11	2173112	86901 BLOOD TYPING RH		86901	1		
04/01/11	2173113	86850 ANTIBODY SCREEN		86850	1		
04/01/11	2180036	CBC W/DIFF		00000	1		7.30
04/01/11	2189206	85025 CBC W/AUTO DIFF		85025	1		

CURRENT	31-60	61-90	91-120	120-150	150+	TOTAL
494.21	-282.97					211.24

Client number: 20000 **PAYMENT DUE UPON RECEIPT**

Statement Date: 04/07/2011
Make Checks payable to: **HealthLab**
* Includes Previous amounts not paid

For billing inquiries, call: (630) 933-6657 Fax: (630) 933-2620

Charges This Statement	494.21
Previous Balance	15,291.67
Payments/Adjustments	15,574.64
Total Amount Due	211.24

Statement of Transactions for:

Invoice# 637

Service	Req/Order	Description of Transaction	Patient ID	CPT	Qty	Credits	Charges
04/01/11	2192846	83914 MUTATION IDENTIFICATIO		83914	3		
04/01/11	2194281	83891 ISOLATION/EXTRACTION N		83891	1		
04/01/11	2194355	83912 MOLECULAR DIAGNOSTICS		83912	1		
04/01/11	2195870	83900 AMPLIFICATION OF NUCLE		83900	1		
04/01/11	2196749	83901 NUCLEIC ACID AMPLIFICA		83901	13		
04/01/11	2196755	83909 MOLECULAR DIAGNOSTICS		83909	1		
04/01/11	2197795	CYSTIC FIBROSIS CARRIER		00000	1		195.91
04/01/11	2199437	83914 X10 MUTATION ID BY ENZ		83914	30		
		Subtotal					234.21
	R110960012	**TEST, BILLING - 02/21/53**	P000000611				
04/06/11	2194998	LEGIONELLA PNEUMOPHILA AB,IG		86713	2		130.00
		Subtotal					130.00
	R110960013	**TEST, INGRID - 04/04/67**	A7320504164				
04/06/11	2194998	LEGIONELLA PNEUMOPHILA AB,IG		86713	2		130.00
		Subtotal					130.00

Client number: 20000 **PAYMENT DUE UPON RECEIPT**

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:**

Fax copy of card, front & back if card contains full billing information, i.e., company name, complete group/ID number **or** complete below.

INSURANCE NAME: _____

POLICY HOLDER: _____ RELATIONSHIP: _____

GROUP NUMBER: _____ ID NUMBER: _____

INSURANCE CO. ADDRESS: _____

PUBLIC AID

Cardholder's Name: _____ Date of Birth: _____

CASE #: _____ RECIPIENT #: _____

PLEASE INCLUDE A COPY OF THE CARD WITH YOUR REPLY.

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

_____

Physician signature required for DX changes/additions: _____

☐☐☐ WARNING ☐☐☐

The documents accompanying this telecopy transmission, including this cover letter, contain confidential or personal information belonging to the sender that is legally privileged. If you are not the intended recipient or the employee or agent responsible for delivering these documents to the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking any action based on the contents of this telecopied information is strictly prohibited.

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** ☐☐☐