

**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 ☐ ☐ ☐**

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