

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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