

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 and 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:
Time _____ Date _____ Signature _____

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 ■■■

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.