Adjustment Request

Please fax information to:
1-866-403-9765

Note: Adjustments requests must be submitted within 30 days of invoice date.
All insurance information must be provided as required by the carrier. Insufficient information will cause delays and may require this form to be returned back to you.

Lab Code MIA			**Invoice #**
Person Submitting Info		**Phone #**	**Date**

Specimen #	**Patient Name**	**Sex**	**DOB**
Bill To/Subscriber Name		**Patient SS#**	
Patient Address	**City**	**State**	**Zip**
Diagnosis/ICD9 Codes For Tests Performed		**Patient Relationship to Subscriber (Circle One)** Self ☐ Spouse ☐ Child ☐ Other ☐	
Insurance Carrier Name	**ID #**		**Group #**
Insurance Carrier Address	**City**	**State**	**Zip**
Referring Physician	**Medicare/Medicaid Provider #**		
Date Of Collection			**Patient Total**

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