Billing Adjustment Form

BILLING ADJUSTMENT FORM

PLEASE CREDIT THESE CHARGES OFF OF OUR ACCOUNT AND BILL WITH PROVIDED INFORMATION:

FACILITY NAME_____ **ACCOUNT #:**_____

Patient Name:_____ **Date of Service**:_____

Street Address:_____

City:_____ **State**:_____ **Zip Code**:_____

Date of Birth:_____ **Physician Name**:_____

ICD-9 Code or Diagnosis:

Name of test +/or CPT code:_____ Cost:

Name of test +/or CPT code:_____ Cost:

Name of test +/or CPT code:_____ Cost:

Name of test +/or CPT code:_____ Cost:

Name of test +/or CPT code:_____ Cost:

Medicare/MA Insurance Company:

ID or Policy #:
Name of Policy Holder:
Group #:

If Medicare-please provide secondary information:

Name of Insurance Company:
Name of Policy Holder:
ID or Policy #:
Group #:

Contact person (for any questions):

Phone #:

PLEASE FORWARD TO RICE LABORATORY BILLING DEPARTMENT-- THANK YOU!

RICE LABORATORY BILLING; **PHONE** **(320) 231-4591**
FAX **(320) 231-4861**