Avera McKennan Regional Laboratory

# Billing Change Request

Submit all requests to: **Avera McKennan Regional Lab**
**Attn: Brenda**
**PO Box 5045, Sioux Falls SD 57117**
**Fax: 605.322.7183 Phone: 605-322-7187 #1**

**Facility:**_____ **Requested By:**_____ **Phone:**_____ **Date:**_____

**SECTION - A**

Patient Name _____
Patient Account # (C#) _____
Date of Service _____
Patient Address _____

**Is patient under 18 yrs of age? If Yes, the following information MUST be supplied:**

Guarantor name: _____
Guarantor address and phone #: _____
Guarantor relationship to patient: _____

**Billing Edit Request:**

☐ **Change from Patient Bill to Client Bill (check one)**

Should all tests under this account number for this DOS be billed back to Client? **Circle: Yes No**

**If NO**, list ONLY those tests to be billed back to the client._____

☐ **Change from Client Bill to Patient Bill**

Is patient self-pay and charges should be billed directly to patient? **Circle: Yes No**

***If YES**, complete section A only. **If NO**, complete all sections.*

**If Medicare is to be billed, was ABN collected on or before date of service?**

***If YES**, a copy must be attached to this form.*

## Please attach copies of all insurance cards.

**SECTION - B**

**Primary Insurance:**
Insurance Company _____
Address _____
City _____ State _____ Zip _____
Policy Holder _____ Relationship to pt:_____
Policy # _____ _____Group#_____

**Secondary Insurance:**
Insurance Company _____
Address _____
City _____ State _____ Zip _____
Policy Holder _____ Relationship to pt:_____
Policy # _____ _____Group#_____

**Third Insurance:**
Insurance Company _____
Address _____
City _____ State _____ Zip _____
Policy Holder _____ Relationship to pt:_____
Policy # _____ _____Group#_____

**Comments:** _____

| Test Name | ICD-9 |
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