

Insurance Adjustment Form

We understand that, on occasion, it may be necessary like Allina Health Laboratory to bill the patient or third party. We will make the adjustment.

Client Name _____
 Requestor's Name _____
 Phone # (____) _____
 Invoice # _____
 Fax # (____) _____

Client name, account number, invoice number, requestor's name phone and fax are all required

ments to your monthly invoice. If you would like the information indicated below, and we



Check here if you included a face sheet

Patient name	Date of service	Date of birth	Insurance company name	Subscriber ID/policy #	Test name or test #	Face sheet enclosed <input type="checkbox"/>
Accn # (from your invoice)	Responsible party	Patient address		Diagnosis code(s)	Physician name (first & last)	
Patient name	Date of service	Date of birth	Insurance company name	Subscriber ID/policy #	Test name or test #	Face sheet enclosed <input type="checkbox"/>
Accn # (from your invoice)	Responsible party	Patient address		Diagnosis code(s)	Physician Name (first & last)	
Patient name	Date of service	Date of birth	Insurance company name	Subscriber ID/policy #	Test name or test #	Face sheet enclosed <input type="checkbox"/>
Accn # (from your invoice)	Responsible party	Patient address		Diagnosis code(s)	Physician name (first & last)	
Patient name	Date of service	Date of birth	Insurance company name	Subscriber ID/policy #	Test name or test #	Face sheet enclosed <input type="checkbox"/>
Accn # (from your invoice)	Responsible party	Patient address		Diagnosis code(s)	Physician name (first & last)	

Include the Accn # from your invoice here

Enter the patient's name here*

Enter the date of service here

The patient's date of birth goes here

Enter the subscriber ID & group #'s Here, Separated by a Slash (/) - ID first

Indicate which test(s) you would like us to bill for here. You can enter "All tests"

Include the patient or responsible party's most recent billing address in this area

Enter the name of the responsible party here. If the patient is responsible, use "Self"

Enter the name of the insurance company here

List the ICD diagnosis code(s) That you want to use for this claim. Narrative coding is also acceptable if you don't have an ICD code

Include the ordering provider's full name (First & last)

E-mail or fax this form within 60 days of receiving your invoice to: **Allina Health Laboratory Billing**
 Email: labbilling@allina.com or Fax: (612) 863-0460

Do not include this form with your invoice mailing as it will not reach the appropriate department and will not be acted upon.

***If adjustments are needed for multiple dates of service on the same patient, each accession must have complete documentation.**