**Billing correspondence letter example**

22-Feb-20XX

ALLINA HEALTH LABORATORY
PO BOX 342
MAIL ROUTE 20201
MINNEAPOLIS, MN 55440-0342
(612) 863-0400
Fax: (612) 863-XXXX

Client ID: XDAA
444-444-4444
Fax: 555-555-5555

DRAWN AT ALLINA HEALTH
PO BOX 342, MR 20201
ATTN: LAB BILLING
MINNEAPOLIS, MN 55440

Dear Client:

Our laboratory is unable to bill for services performed on behalf of the patient listed below due to missing data. Please supply the missing information as soon as possible and fax this form back to us at 612-262-0951. Thank you.

**Ordering Physician:**

**Patient:** **LASTNAME, FIRSTNAME** **Patient ID: XXXXXXX** **DOB: 01/02/2003**
**Accession #:** **X12121231234** **Req #: 12-999999999** **SSN: XXX-XX-XXXX**
**DOS:** **21-Nov-2012**

**Tests Ordered:** 00002634 VENIPUNCTURE
00819714 FACTOR X CHROMOGENIC

Please provide information on whom to bill for these services. If third party, please provide complete insurance billing information and all patient demographics.

| | **Our Records** | **Corrections** |
|---|---|---|
| Payor Name: | NON-SPECIFIED PAYOR | _____ |

Please provide an ICD diagnosis code.

| | **Our Records** | **Corrections** |
|---|---|---|
| Diagnosis Code 1: | | _____ |

Please provide the full name (First, MI, Last) of the ordering physician along with ***NPI Number **, Credentials and Specialty.

| | **Our Records** | **Corrections** |
|---|---|---|
| Ordering Physician: | | _____ |

Sincerely,

ALLINA HEALTH LABORATORY
XDAA