Manual Request Billing Instruction Guide

If you wish us **to bill your clinic or facility**, complete the following sections of the request form:

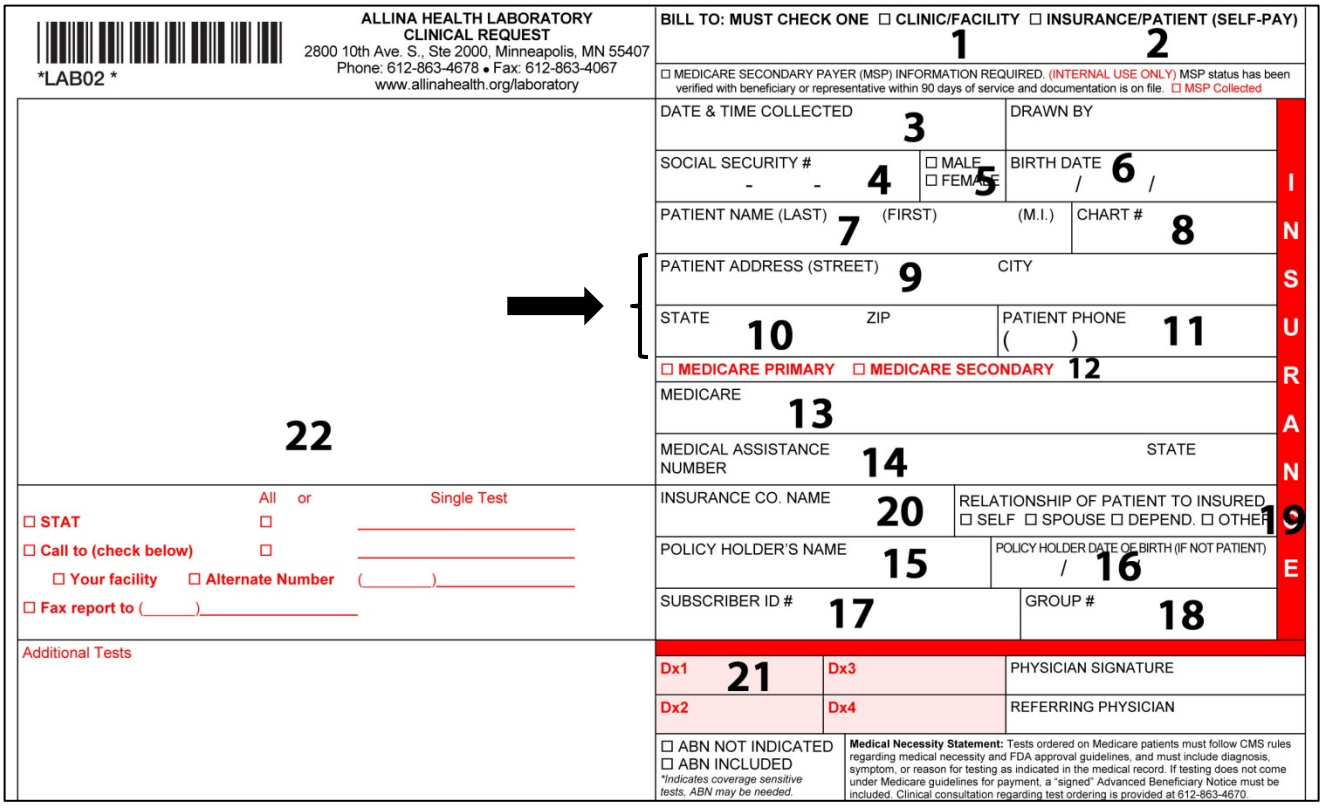
1. **YOU MUST MARK** "Clinic/Facility"
3. Date & Time Collected
4. Patient's Social Security Number (optional/not required)
5. Sex
6. Birth Date
7. Patient's Name (Last, First, MI)
9. *Patient's Address - Street & City*
10. *Patient's Address - State & Zip*
11. Patient's Telephone Number
22. Ordering Provider

If you wish us **to bill the patient directly**, complete the following sections of the request form:

2. **YOU MUST MARK** "Insurance/Patient (Self-Pay)"
3. Date & Time Collected
4. Patient's Social Security Number (optional/not required)
5. Sex
6. Birth Date
7. Patient's Name (Last, First, MI)
9. *Patient's Address - Street & City*
10. *Patient's Address - State & Zip*
11. Patient's Telephone Number
15. Guarantor listed here if patient under 18 years of age
21. Diagnosis*
22. Ordering Provider

If you wish us **to bill Medicare, Medicaid or other third-party payers**, we must have the following sections of the request form completed:

2. **YOU MUST MARK** "Insurance/Patient (Self-Pay)"
3. Date & Time Collected
4. Patient's Social Security Number (optional/not required)
5. Sex
6. Birth Date
7. Patient's Name (Last, First, MI)
9. *Patient's Address (Street & City)*
10. *State & Zip*
11. Patient's Telephone Number
12. For Medicare patients only, the appropriate box on the requisition should be checked to indicate if Medicare is Primary or Secondary.
13. Medicare #
14. Medical Assistance # and state in which it was issued
15. Policy Holder (If Not Patient)–also used for Guarantor if patient under 18 years of age. If different, please list
16. Policy Holder's Date of Birth
17. Member/Policy #
18. Group #
19. Relationship of Patient to Insured
20. Insurance Company Name
21. Diagnosis*
22. Ordering Provider



*ICD codes or clear diagnostic symptom descriptions are required to the highest specificity possible.