Billing Change Request Form

To change the billing type, fax completed form to:
(217)788-5579

Change Billing To:

- ☐ Insurance Bill
- ☐ Client Bill
- ☐ All Tests (Including Pathology)
- ☐ All Tests (Except Pathology)
- ☐ Only these tests: ______________________________

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Client Name			
Person Submitting Information	**Phone#**		**Date**
Patient Name	**Date of Birth**		**Sex**
Date of Service	**Ordering Provider**		
Diagnosis			

Demographic sheet may be submitted in place of filling out this section of the Billing Change Request Form			
Patient Address	**City**	**State**	**Zip**
Insurance Carrier Name	**Policy ID#**		**Group#**
Insurance Carrier Address	**City**	**State**	**Zip**
Subscriber Name	**Subscriber Date of Birth**	**Patient Relationship to Subscriber (Circle One)** Self Spouse Child Other	

Form must be completed for billing changes to be processed. Include medically necessary diagnosis for all test billed to the patient's insurance. Insufficient information will result in delay of the billing change request.

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