Regional West
Laboratory Services

4021 Avenue B
Scottsbluff, NE 69361

# REQUEST FOR BILLING CHANGE

Date: _____

**Last Name:** _____ **First Name:** _____

DOB: _____ SS#: _____

**Billing Address:** _____

City: _____ State: _____ Zip: _____ Phone: _____

**Bill to:** ☐ Account ☐ Insurance ☐ Medicare ☐ Medicaid

| **Primary** | **Secondary** |
|---|---|
| Insurance Company: _____ | Insurance Company: _____ |
| Insurance Billing Address: _____ | Insurance Billing Address: _____ |
| City, State, Zip: _____ | City, State, Zip: _____ |
| Policy Holder: _____ | Policy Holder: _____ |
| Policy Holder DOB: _____ | Policy Holder DOB: _____ |
| Policy/Medicare/ Medicaid No: _____ | Policy/Medicare/ Medicaid No: _____ |
| Group No: _____ | Group No: _____ |

Date of Service: _____

Laboratory Test(s) Ordered: _____

Ordering Physician: _____

**Diagnosis:** _____

Print Name: _____ Date: _____

Signature: _____ Title: _____

Return by Fax to:
(308) 632-4745

(for office use only) Encounter No. _____

09/09