MARQUETTE GENERAL HEALTH SYSTEM

Billing Change Request Form

Facility Name: _____ **Client Acct #**_____

Requested By: _____ **Date:** _____

Phone #_____

Request is to: _____

_____

_____

_____

Reason for Request: _____

_____

Attach:

1. Patient's current insurance/demographic information.
2. Appropriate Diagnosis (ICD-9 Format) for tests ordered.
3. Copy of original laboratory requisition or billing statement.

Send to: MGHS Laboratory
580 W College Ave.
Marquette, MI 49855

Or

Fax to: 906-225-3849

*Note: An additional Processing Charge may be applied to requests that are sent more than 30 days after the original date of service.

This area is for MGHS Use only

Request received by: _____ Date: _____

Authorized by: _____ Date: _____

Change Made by: _____ Date: _____