Billing Adjustments

Please FAX this form to (605) 328-5453

All Fields below are REQUIRED to process any changes

SANFORD Laboratories

Sanford Laboratories Account number as it appears on your bill: _____

Statement Date: _____

Adjustment Requested by: (please PRINT legibly) _____

The Sanford Laboratories Billing Adjustment Form is used for two purposes: 1) to change Client Bill to Patient Bill or 2) to adjust charges due to discounted services that may not have been reflected on invoice. **Sanford Laboratories must receive adjustments within 30 days** of client receiving the invoice. *Charges will not be reversed beyond 90 days and the client will be liable for all charges.* Please include ALL requested information in order for the request to be processed. Call 800-522-2561, ext 85408 if you have any questions.

MEDICARE, MEDICAID, AND PRIVATE INSURANCE ADJUSTMENTS (Please PRINT clearly)

E #	Patient's Name and Guarantor Name if patient is a child	Medicare # (if applicable)	Physician	Test	Diagnosis Code
Date of service	Street Address	Medicaid # (if applicable)		Test	Diagnosis Code
Patient Date of Birth	City State	Zip		Test	Diagnosis Code
Other Insurance ID, Group #, Address			Other insurance Subscriber Name and Date of Birth		

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Date of service	Street Address	Medicaid # if applicable		Test	Diagnosis Code
Patient Date of Birth	City State	Zip		Test	Diagnosis Code
Other Insurance ID, Group #, Address			Other insurance Subscriber Name and Date of Birth		

Important: To avoid needing to use the Billing Adjustment Form, please ensure all lab orders and/or requisitions are completed with all required billing informaton and the correct billing type is indicated.

Accounts Receivable
PO Box 5056
Sioux Falls, SD 57117-5056
(605) 328-5485, (800) 522-2561, ext. 85485

Billing Adjustments

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Date of service	Street Address	Medicaid # if applicable		Test	Diagnosis Code
Patient Date of Birth	City State	Zip		Test	Diagnosis Code
Other Insurance ID, Group #, Address			Other insurance Subscriber Name and Date of Birth		

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Date of service	Street Address	Medicaid # if applicable		Test	Diagnosis Code
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Date of service	Street Address	Medicaid # if applicable		Test	Diagnosis Code
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Patient Date of Birth	City State	Zip		Test	Diagnosis Code
Other Insurance ID, Group #, Address			Other insurance Subscriber Name and Date of Birth		

Total Amount Credited ____________________ Total Amount Reversed ____________________

Total Amount Credited refers to charges credited because of discounting
Total Amount Reversed refers to changing a Client Bill charge to a Patient Bill charge