ENH EVANSTON NORTHWESTERN HEALTHCARE
Laboratory Services
9811 Woods Drive, Suite H180, Skokie, IL 60077

Client Invoice Adjustment Form
Fax completed form to: (847) 663-2190
Questions contact Billing Department: (847) 663-2125

Adjustment requests must be submitted within 30 days of the invoice date. Complete insurance information is required to process the adjustment request. Adjustments will only be made for all test(s) per patient for a specific date of service.

ENHLS Account No:________**Account/Practice Name:**_____________________________________

Account Contact:____________________________________**Telephone:**______________________

Invoice Date:_____________________

Patient Name:_______________________________________**Sex:**_________**DOB:**______________

Address:_____________________________________**City:**_____________________**State:**________

Test(s):____

ICD9 Codes for Each Test(s) Limit 4:____

Insurance Carrier:______________________**Insured ID:**_______________**Group No:**__________

Carrier Claims Address:________________________**City:**_____________________**State:**________

Ordering Physician:_________________________________**UPIN/NPI:**______________________

Patient Name:_______________________________________**Sex:**_________**DOB:**______________

Address:_____________________________________**City:**_____________________**State:**________

Test(s):____

ICD9 Codes for Each Test(s) Limit 4:____

Insurance Carrier:______________________**Insured ID:**_______________**Group No:**__________

Carrier Claims Address:________________________**City:**_____________________**State:**________

Ordering Physician:_________________________________**UPIN/NPI:**______________________

Patient Name:_______________________________________**Sex:**_________**DOB:**______________

Address:_____________________________________**City:**_____________________**State:**________

Test(s):____

ICD9 Codes for Each Test(s) Limit 4:____

Insurance Carrier:______________________**Insured ID:**_______________**Group No:**__________

Carrier Claims Address:________________________**City:**_____________________**State:**________

Ordering Physician:_________________________________**UPIN/NPI:**______________________