

## MONTHLY STATEMENT ADJUSTMENTS

Account #: \_\_\_\_\_

Statement Month: \_\_\_\_\_

Please make the necessary adjustments to your account. Complete all of the information fields listed below for each patient so that we can remove the charges from your account and bill the indicated insurance company. As an alternative we will accept a demography record from your medical records computer that contains all of the information listed below.

Please indicate which company the adjustments apply to:

Physicians Laboratory Services, Inc. \_\_\_\_\_

Physicians Laboratory P.C. \_\_\_\_\_

<b>Patient Name</b>	<b>PLS Account #</b>	<b>Date of Service</b>	<b>Date of Birth</b>	<b>Sex</b>	<b>ICD-10 Codes Diagnosis Code Required for All</b>
<b>Patient Address</b>	<b>Patient City</b>	<b>Patient State</b>	<b>Patient Zip</b>		
<b>Insurance Company</b>	<b>Insurance ID #</b>	<b>Ins. Group #</b>	<b>Insurance Address</b>		
<b>Card Holder Name</b>	<b>Relationship to Patient</b>				

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