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. ________

****PLEASE FAX COMPLETED FORM TO 402-932-5136****

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

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