



Amendment Form

FAX THIS FORM TO CDD: 1-888-858-8664

Laboratory Amendment: Request for correction/amendment of Patient Demographics and Third Party Billing Information.

CDD Account Number: _____ Date of Service: _____

Accession Number: _____ Type of correction: _____

Patient Name: _____ Contact Name: _____

Please complete all requested information below for Third Party Billing Amendments.

Insurance Name: _____ Insurance ID#: _____

Group Number: _____ ICD-9 code(s): _____, _____

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

Information provided by:

Print Name: _____ **Signature:** _____

Title: _____ **Date:** _____

Amended Test Request: For specimen(s) CDD receives in an incorrect/inappropriate specimen collector for the test originally requested, we will hold the specimen(s) up to 5 days.

Instructions:

- **AFTIS sites** – Register patient and select correct lab test
- Process barcode label, affix label below, fax completed form to CDD, and transmit data
- **Carebill sites** – Complete a new Carebill for patient
- Select appropriate label(s) from Carebill and affix label(s) below
- Fax copy of Carebill along with this amendment form to CDD

{ **Place Barcode Label(s) Here** }

Center for Disease Detection Use Only:	Date Received _____
If denied, check reason for denial:	Amendment has been: Accepted Denied
PHI was not submitted by requesting client _____	
PHI was not submitted with laboratory request _____	
Incomplete Third Party Information _____	
Name of staff member: _____	Title: _____