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: ____________________________