



# ORML

## REGIONAL MEDICAL LABORATORY

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### PHYSICIAN REQUEST TO BILL PATIENT/PATIENT'S INSURANCE Attn: Billing Client Team

Date of Request: \_\_\_\_\_ Invoice Number: \_\_\_\_\_

Requester Name: \_\_\_\_\_

Client Code & Name: \_\_\_\_\_ (at lower left corner of your invoice)

<b>Patient Name:</b> _____	SSN: _____	DOB: ____/____/____
Billing Address: _____	City: _____	State: ____ Zip: _____
Telephone No: _____		
<b>Insurance Co:</b> _____		
Claim Address: _____	City: _____	State: ____ Zip: _____
ID/Policy No: _____	Group No: _____	
Insured:	<input type="checkbox"/> Self	
	<input type="checkbox"/> Other than Self (please fill out following info)	
	Relationship to Patient: _____	
	Name: _____	SSN: _____ DOB: ____/____/____
<b>Date of Service:</b> ____/____/____ <b>** PLEASE SUBMIT ADVANCE BENEFICIARY NOTICE (ABN) IF APPLICABLE</b>		
Tests/CPTs: _____	_____	_____
Diagnoses: _____	_____	_____
_____		
<b>Patient Name:</b> _____	SSN: _____	DOB: ____/____/____
Billing Address: _____	City: _____	State: ____ Zip: _____
Telephone No: _____		
<b>Insurance Co:</b> _____		
Claim Address: _____	City: _____	State: ____ Zip: _____
ID/Policy No: _____	Group No: _____	
Insured:	<input type="checkbox"/> Self	
	<input type="checkbox"/> Other than Self (please fill out following info)	
	Relationship to Patient: _____	
	Name: _____	SSN: _____ DOB: ____/____/____
<b>Date of Service:</b> ____/____/____ <b>** PLEASE SUBMIT ADVANCE BENEFICIARY NOTICE (ABN) IF APPLICABLE</b>		
Tests/CPTs: _____	_____	_____
Diagnoses: _____	_____	_____

\*\*\*\*\*All information is required in order to file patient's insurance and identify the client. \*\*\*\*\*  
Please understand there may be times when the original order was designated to Bill Client and timely filing to the patient's insurance has been exceeded at the time of this request. In these instances we may be unable to move the charges from the client account to the patient's account. You will be notified if we are unable to comply with your request. Thank you.