DiagnosTechs™
CLINICAL & RESEARCH LABORATORY

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DiagnosTechs Provider Refund Request Form

Cancellation/Refund Policy:

All refund requests must be received in writing and within 60 days of test cancellation. All refunds are subject to a $25.00 cancellation fee. All requests must be received on this Refund Request Form.

PLEASE ENSURE THAT ALL FIELDS ARE PROPERLY FILLED OUT. INCOMPLETE AND/OR ILLEGIBLE FORMS WILL NOT BE PROCESSED. FAX COMPLETED FORMS TO 425-264-0614 or EMAIL COMPLETED FORMS TO providerbilling@diagnostechs.com

DTI Account Number: _____

Date of Request: ____ / ____ / _____ (mm/dd/yyyy)

Reason: _____

Clinic Name: _____

Physician: _____

Mailing Address: _____

City: _____ State/Prov: _____ Zip/Postal: _____

I, _____ have read through the refund policy. I understand that my refund is subject to a $25.00 fee.

Signature: _____ Date: ____ / ____ / _____ (mm/dd/yyyy)

FOR LABORATORY USE ONLY
RECEIVED:
AMOUNT APPROVED:
APPROVED BY:
DATE: