

DignosTechs Patient 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 425-748-9303 or EMAIL COMPLETED FORMS TO billing@dti-wa.com

Accession Number: ____ - _____

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

Reason: _____

First Name: _____

Last Name: _____

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: