

## DignosTechs 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 425-748-9303 or EMAIL COMPLETED FORMS TO [billing@dti-wa.com](mailto:billing@dti-wa.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)

<p><b>FOR LABORATORY USE ONLY</b></p> <p>RECEIVED:</p> <p>AMOUNT APPROVED:</p> <p>APPROVED BY:</p> <p>DATE:</p>
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