***************DUPLICATE ORDERS/CREDIT REQUEST***************

Forward to:
Lab Billing Office
Bassett Medical Center Lab T1 Clinic Building
Fax: 607-547-5438
Email:LabBillingStaff@bassett.org

Patient Name: ____

Medical Record #:____

Date of Service: ____

Visit numbers: ____

Tests to be credited: ____

____

Reason for credit: ___Duplicate ___Ref Lab Duplicate
___Other (Please specify)____

Person /Lab requesting credit: ____

Date: ____

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