EGL Genetics | Eurofins Clinical Diagnostics

PATIENT INSURANCE BENEFIT VERIFICATION FORM & BILLING AUTHORIZATION

Return by fax to: (470) 378-2250 ☐ **PRENATAL SAMPLE**

Insurance benefits cannot be obtained for the requested services until a **completed**, **signed** copy of this form is received in our office. The verification will be provided within 72 hours after receipt and is good for 30 days. This information will be released to your insurance carrier for benefit verification. Please note that the information provided on a verification of benefits is not a guarantee of payment on our services. Prior verifications and authorizations only verify that the requested service meets the plan's definition of medical necessity.

Date:____/____/_____ Patient Name:_____

Gender: Male ☐ Female ☐ Patient Date of Birth:____/____/_____

Patient Address:_____ Contact Phone: (___) _____-_____ H W C

Email:_____ City, State, Zip:_____

Referring/Ordering MD Information:

Physician Name:_____ **NPI** #:_____

Physician Address:_____ City, State, Zip:_____

Physician Phone: (_____) _____-_____ Fax: (_____) _____-_____

Genetic Counselor/Contact:_____ Phone: (_____) _____-_____

Email:_____

HMO PCP Name (if not the ordering MD):_____ Phone: (_____) _____-_____

DIAGNOSIS:_____

ICD-10 CODES: 1)_____ **2)**_____ **3)**_____ **4)**_____

TESTS REQUESTED **#1:** _____ _____

#2: _____ _____

#3 _____ _____

Test Code (From website) ***Test Name***

Insurance Information (Include an enlarged copy of the insurance card, both front and back)

Policyholder's Name:_____

Relationship to Patient:_____ Policyholder's Date of Birth: _____/_____/_____

Group #:_____ ID:_____

Insurance Company Name:_____ Policy/Plan:_____

Insurance Claims Filing Address:_____

Insurance Phone: (_____) _____-_____ Insurance Fax: (_____) _____-_____

HMO Authorization #:_____

☐ Pre-Verification ONLY ☐ Pre-Verification and Insurance Billing ☐ Insurance Billing ONLY

Authorization to contact health insurance carrier, and release confidential medical information:

I understand EGL Genetics will contact my insurance carrier regarding coverage of genetic testing. I authorize the disclosure of my insurance benefit coverage and payment information to EGL Genetics. I authorize my physician or other medical entity to release confidential medical information to EGL Genetics concerning my medical history. I authorize EGL Genetics to release confidential medical information to my health insurance carrier to facilitate reimbursement of my medical fees.

Authorization to assign benefits, and accept financial responsibility for my account:

I assign and authorize insurance payments to EGL Genetics. I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State or Federal law. A duplicate or faxed copy of this authorization is considered the same as the original document.

Authorization to bill health insurance carrier:

By signing below, I accept that I am covered by insurance and authorize EGL Genetics ("EGL") to give my designated insurance carrier, health plan, or third party administrator (collectively "Plan") my health information for purposes of payment of bills, my continued care or treatment, and healthcare operations. I authorize my physicians or any relevant facility to release my health information to EGL for the purposes of payments of bills or claims. I understand that EGL will attempt to contact me to inform me of my estimated out-of-pocket responsibility if it exceeds $100. I understand that I am accountable to pay my out-of-pocket responsibility as determined by my insurance provider.

Signature of Patient or Guardian:_____ Date: _____/_____/_____

Printed Name of Patient or Guardian:_____ Date: _____/_____/_____