

PATIENT INSURANCE VERIFICATION FORM

Tax ID 74-1613878

Return by fax to 713-798-4187 or e-mail: medgenbilling@bcm.edu

Insurance benefits cannot be obtained for your requested testing until a completed, signed copy of this form is received in our office. This information will be released to your insurance carrier for benefit verification.

Date: ____ / ____ / ____ SSN #: _____

Patient Name: _____ Patient Date Of Birth: ____ / ____ / ____

Patient Address: _____ City, State, Zip: _____

Indicate your contact preference (please circle one): **HOME** **WORK** **FAX** **E-MAIL**

Home Phone: (____) _____ Work Phone: (____) _____ Fax: (____) _____

E-mail: _____

Referring/Ordering MD Information:

Physician Name: _____ NPI #: _____

Physician Address: _____ City, State, Zip: _____

Physician Phone: (____) _____ Fax: (____) _____

Ref MD TPI # (Texas Medicaid Only): _____ Contact E-mail: _____

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

Medical Genetic Labs Test Code (required): _____

ICD-9 CODES (Diagnosis/Symptoms): 1) _____ 2) _____

Please fax legible copies of the insurance card, or complete the required information below:

Policyholder's Name: _____ SS or ID #: _____

Relation to Patient: _____ Policyholder's Date Of Birth: ____ / ____ / ____ Gender (circle one): M F

Group #: _____ Policy/Plan: _____

Insurance Company Name: _____ Policyholder's Employer: _____

Ins. Claims Filing Address: _____

Ins. Company Phone: (____) _____ Fax: (____) _____

Texas Medicaid Info (Fax a copy of the Medicaid Form 3087, or complete information below):

Texas Medicaid #: _____ Traditional Medicaid or Medicaid HMO (circle one)

Medicaid HMO Plan: _____ HMO Authorization# _____ Effctiv. Date: ____ / ____ / ____

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

I understand BCM, Medical Genetic Laboratories will contact my insurance carrier regarding coverage of genetic testing. I authorize the disclosure of insurance benefit coverage and payment information to BCM, Medical Genetic Laboratories. I authorize my physician or other medical entity to release confidential medical information to BCM, Medical Genetic Laboratories concerning my medical history. I authorize BCM, Medical Genetic Laboratories to release confidential medical information to my insurance health 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 BCM, Medical Genetic Laboratories. 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.

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

Printed Name of Patient or Guardian: _____