BAYLOR GENETICS

BAYLOR GENETICS
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PATIENT INSURANCE BENEFIT VERIFICATION FORM

INSTRUCTIONS

1. Complete all REQUIRED sections below.
2. Fax or email this form with a copy of the front and back of your insurance card.

If a prior authorization or pre-determination is required by the patient's insurance plan, we will ask you for additional information such as clinical notes and a letter of medical necessity.

PATIENT INFORMATION (REQUIRED)

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY)

Address | City | State | Zip

Patient Email | Patient Phone | Biological Sex: ◯ Female ◯ Male

REFERRING INFORMATION (REQUIRED)

Ordering Physician Name | NPI Number | Practice Name | Phone | Fax

Address | City | State | Zip

GENETIC COUNSELOR

Name | Email | Phone | Fax

GENETIC TEST INFORMATION (REQUIRED)

Test Code(s) And Test Name(s)

All applicable ICD-10 codes with Diagnosis

PATIENT INSURANCE INFORMATION

IF COPY OF FRONT AND BACK OF INSURANCE IS NOT AVAILABLE, PLEASE COMPLETE ALL FIELDS BELOW.

Policyholder Name | Relationship to Patient | ID Number

Group Number | Authorization Number (If Obtained) | Company Name

Address | City | State | Zip

Phone | Fax