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 ______

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 ______