BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

TEST REVISION AUTHORIZATION FORM (TRAF)

IMPORTANT REMINDERS

For Add-on Test:

1. If Ordering Physician has changed, a NEW REQUISITION FORM IS REQUIRED. Please note, the "Add-on Test" request MUST include asignature authorization from the party to be billed.
2. If patient sample was initially handled by your Send-out Department, this add-on request will need to originate from the same Send-out Department.
3. Client Services will contact you once the test is added. If you do not hear from us within 24 hours of submission of this form please contact us at 1-800-411-GENE.

For Cancellation:

Cancellation requests are processed only if acceptable cancellation documentation is received before 5 pm the next business day from the day of sample receipt. Cancellation requests received after this time will not be accepted.

PATIENT INFORMATION & REQUEST

* REQUIRED FIELDS

Last Name * _____ First Name * _____ MI _____ Date of Birth (MM / DD / YYYY) * ____ / ____ / ____

Account # _____ Baylor Genetics Lab # _____ Family # _____ MR # _____

PLEASE SPECIFY: *

◯ ADD-ON TEST ◯ CANCELLATION

Test Code * _____ Test Name * _____

If sequential testing is requested, specify the testing sequence * :

ADDITIONAL INFORMATION (such as new accession number) * :

CONTACT INFORMATION & SIGNATURE OF AUTHORIZATION (ALL FIELDS ARE REQUIRED TO PROCESS REQUEST)

Printed Name _____ Institution _____

Phone _____ Fax _____ Email _____

APPROVED BY:

Printed Name _____ Institution _____

Signature _____ Date (MM / DD / YYYY) ____ / ____ / ____

BILLING INFORMATION

☐ Check here if billing information is the same as the original test request. If billing information is different, please fill out second page and submit with add-on request.

Note: Please notify your appropriate lab personnel if testing added is to be billed institutionally.

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IMPORTANT NOTICE

One of the three following billing options must be indicated below. Please forward all billing questions to: billing@bmgl.com.

PATIENT INFORMATION

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

Address | City | State | Zip

Phone | Email

PAYMENT OPTIONS

☐ **INSTITUTION**

Institution Name

Institution Code

Contact Name

Email (Required)

Billing Address Line 1

Billing Address Line 2

City

State | Zip

Phone | Fax

☐ **INSURANCE**

PROVIDE A LEGIBLE PHOTOCOPY OF THE FRONT & BACK OF THE INSURANCE CARD OR HMO/MEDICAID HMO AUTHORIZATION/REFERRAL.

Please refer to the Financial Policy at www.bmgl.com for complete insurance filing information and managed care contract list. Insurance is filed to our contracted carriers as a client service courtesy. Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. HMO policies must have required approved authorizations. Baylor Miraca Genetics Laboratories cannot bill out-of-state welfare programs. We accept authorized Texas Medicaid HMO covered charges for genetic testing. Please contact our office prior to submitting a Texas Medicaid sample. Contact medgenbilling@bcm.edu with questions.

Ordering Provider

ICD9 Diagnosis Code(s) (Required)

◯ PPO, POS, Commercial Insurance
Provide complete member information with legible front & back photocopy of insurance card.

◯ HMO
Provide approved authorization #: _____
and attach legible front & back photocopy of insurance card.

◯ Texas Medicaid HMO
Provide approved authorization #: _____
and contact Billing at 713.798.5849.

☐ **SELF PAY** (PAYMENT MUST ACCOMPANY SAMPLE)

☐ CREDIT CARD (PLEASE SELECT ONE):

◯ AMEX ◯ DISCOVER ◯ MC ◯ VISA

Valid Card #

Exp. Date (MM / YYYY) | CVC Code

Cardholder Printed Name

Cardholder Signature

☐ CHECK/MONEY ORDER

Check/Money Order #

Amount Enclosed

INSURED MEMBER'S INFORMATION

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

Policy # | Social Security # | Group #

Insurance Company Name | Insurance Company Phone

Insurance Company Address | City | State | Zip

I AUTHORIZE BAYLOR MIRACA GENETICS LABORATORIES TO FURNISH ANY MEDICAL INFORMATION REQUESTED ON MYSELF, OR MY COVERED DEPENDENTS. IN CONSIDERATION OF SERVICES RENDERED, I TRANSFER AND ASSIGN ANY BENEFITS OF INSURANCE TO BAYLOR MIRACA GENETICS LABORATORIES. I UNDERSTAND I AM RESPONSIBLE FOR ANY CO-PAY, DEDUCTIBLES, OR NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. I UNDERSTAND I AM FULLY RESPONSIBLE FOR PAYMENT OF MY ACCOUNT IF THE BAYLOR MIRACA GENETICS LABORATORIES IS NOT A PARTICIPANT WITH MY HEALTH PLAN, AND MY HEALTH PLAN DOES NOT FULLY REIMBURSE MY MEDICAL SERVICES DUE TO LACK OF AUTHORIZATION OR MEDICAL NECESSITY.

Printed Name | Signature | Date (MM / DD / YYYY)