

HENRY FORD CENTER FOR PRECISION DIAGNOSTICS

Henry Ford Center for Precision Diagnostics Henry Ford Hospital Pathology and Laboratory Medicine Clinic Building, K6, Core Lab, E-655 2799 W. Grand Blvd. | Detroit, MI 48202

PATIENT DEMOGRAPHIC / INSURANCE / BILLING FORM

(This form MUST be submitted at time of specimen submission.)

Required Patient Information

Ordering Physician Information

Primary Insurance Information INSURANCE BILL (include copy of both sides of insurance card) Patient Relation to Policy Holder?	Name:		Gender: M F	Name:		
Potient's Email Address:	MRN:	DOB:	//	Address:		
Patient's Email Address:	Address:			City:	State:	Zip:
Patient's Primary Phone #: Physician Signature: Patient's primary language if not English: Patient's patient's who do not meet medical criteria for testing - only applies to patients with often only applies to patient's more different patients who do not meet medical criteria for testing - only applies to patient's more different patients who do not meet medical criteria for testing - only applies to patient's patient'	City:	State:	_ Zip:	Phone:	Fax:	
Patient's primary language if not English: ADVANCE BENEFICIARY STATEMENT OF NONCOVERAGE (ABN) Note: A completed Advance Beneficiary Notice (ABN) of coverage is required for Medicare patients who do not meet medical criteria for testing - only applies to patients with original Medicare (see website for ABN form). Billing Information Primary Insurance Information Name of Policy Holder: Patient Relation to Policy Holder? Self Spouse Child Date of Birth of Policy Holder: Insurance Co: Group: ID: Insurance Claims Filing Address: Policy/Plan: Insurance Co: phone number: Insurance Co: ID: Insurance Co: phone number: Insurance Co: Group: ID: Insurance Co: phone number: Insurance Co: pho	Patient's Email Address:			_ Email Address:		
Patient's primary language if not English: ADVANCE BENEFICIARY STATEMENT OF NONCOVERAGE (ABN) Note: A completed Advance Beneficiary Notice (ABN) of coverage is required for Medicare patients who do not meet medical criteria for testing - only applies to patients with original Medicare (see website for ABN form). Billing Information Primary Insurance Information Name of Policy Holder: Patient Relation to Policy Holder? Self Spouse Child Date of Birth of Policy Holder: Insurance Co: Group: ID: Insurance Claims Filing Address: Policy/Plan: Insurance Co: phone number: Insurance Co: ID: Insurance Co: phone number: Insurance Co: Group: ID: Insurance Co: phone number: Insurance Co: pho	Patient's Primary Phone #:			_ Physician Signature:		
ADVANCE BENEFICIARY STATEMENT OF NONCOVERAGE (ABN) Note: A completed Advance Beneficiary Notice (ABN) of coverage is required for Medicare patients who do not meet medical criteria for testing - only applies to patients with Original Medicare (see website for ABN form). Billing Information Primary Insurance Information INSURANCE BILL (include copy of both sides of insurance card) Patient Relation to Policy Holder: Insurance Co.: Group: Policy/Plen: Insurance Co, phone number: Secondary Insurance Information INSURANCE BILL (include copy of both sides of insurance card) Name of Policy Holder: Insurance Co, Fax number: Secondary Insurance Information INSURANCE BILL (include copy of both sides of insurance card) Name of Policy Holder: Insurance Co, Fax number: Secondary Insurance Information INSURANCE BILL (include copy of both sides of insurance card) Name of Policy Holder: Insurance Co is insurance Co, Fax number: Secondary Insurance Co, Fax number: Secondary Insurance Co, Fax number: Insurance Co, Fax number: Insurance Co, Fax number: Insurance Co, Fax number: Insurance Prior Authorization #: Insurance Prior Authorization #: Insurance Co, Fax number: Insurance Co, Fax number: Insurance Co, Fax number: Insurance Co, Fax number: Policy/Plan: Insurance Co, Fax number: PATIENT BILL CREDIT CARD PAYMENT (make check payable to Henry Ford Center for Precision Diagnostics Attach check to this form) Amount \$\frac{1}{2}\$ Amount \$\frac{1}{2}\$ Amount \$\frac{1}{2}\$ Amount \$\frac{1}{2}\$ Amount \$\frac{1}{2}\$ Amount \$\frac{1}{2}\$ Card Number: Card						
Primary Insurance Information INSURANCE BILL (include copy of both sides of insurance card) Name of Policy Holder:	Note: A completed Advance Beneficia	ary Notice (ABN)	of coverage is required f	or Medicare patients who do not r	meet medical cr	iteria for testing - only applies
Patient Relation to Policy Holder?	Billing Information Primary Insurance Information					
Insurance Co:	INSURANCE BILL (include copy of both sides of insurance card)			Name of Policy Holder:		
Insurance Claims Filing Address: Policy/Plan:	Patient Relation to Policy Holder? 🗖 Self 📮 Spouse 📮 Child			Date of Birth of Policy Holder:		
Insurance Prior Authorization #: Insurance Co. phone number: Secondary Insurance Information INSURANCE BILL (include copy of both sides of insurance card) Patient Relation to Policy Holder?	Insurance Co.:		Group:	ID:		
Insurance Co. phone number:	Insurance Claims Filing Address:			Policy/Plan:		
Secondary Insurance Information INSURANCE BILL (include copy of both sides of insurance card) Name of Policy Holder: Patient Relation to Policy Holder?				_Insurance Prior Authorization #:		
Name of Policy Holder: Patient Relation to Policy Holder?	Insurance Co. phone number:			Insurance Co. Fax number:		
Patient Relation to Policy Holder?	Secondary Insurance Informatio	'n				
Insurance Co.:	INSURANCE BILL (include copy of both sides of insurance card)			Name of Policy Holder:		
Insurance Claims Filing Address: Policy/Plan:	Patient Relation to Policy Holder?	Self 🗖 Spouse	☐ Child	Date of Birth of Policy Holder:		
Insurance Prior Authorization #: Insurance Co. phone number: Insurance Co. Fax number: Insurance Co	Insurance Co.:		Group:	ID:		
Insurance Co. phone number:	Insurance Claims Filing Address:			Policy/Plan:		
CHECK PAYMENT (make check payable to Henry Ford Center for Precision Diagnostics Attach check to this form) Amount \$:				_Insurance Prior Authorization #:		
CHECK PAYMENT (make check payable to Henry Ford Center for Precision Diagnostics Attach check to this form) Amount \$:	Insurance Co. phone number:			_Insurance Co. Fax number:		
Attach check to this form and submit at time of specimen submission. CREDIT CARD PAYMENT I only approve the amount listed to be charged to my credit card account. If estimated charges listed above are greater than the amount approved, Henry Ford Center for Precision Diagnostics will notify me that additional payment is required. Note to patient: Testing will not proceed until payment is received.) Cardholder Name:	PATIENT BILL					
CREDIT CARD PAYMENT I only approve the amount listed to be charged to my credit card account. If estimated charges listed above are greater than the amount approved, Henry Ford Center for Precision Diagnostics will notify me that additional payment is required. Note to patient: Testing will not proceed until payment is received.) Cardholder Name:	CHECK PAYMENT (make check pa	yable to Henry F	Ford Center for Precision D	Diagnostics Attach check to this for	rm)	Amount \$:
Rote to patient: Testing will not proceed until payment is received.) Cardholder Name: Cardholder Signature: Card Number: Card Number: Curd Number: Cu	Attach check to this form and submit	at time of specin	nen submission.			
Card Number: CVC #:	greater than the amount approve	ed, Henry Ford	Center for Precision D	rged to my credit card accoun Diagnostics will notify me that	t. If estimate additional pa	d charges listed above are yment is required.
Authorization to contact health insurance carrier, and release confidential medical information: I understand Henry Ford Center for Precision Diagnostics may contact my insurance carrier regarding coverage of genetic testing. I authorize the disclosure of insurance benefit coverage and payment information to Henry Ford Center for Precision Diagnostics. I authorize my physician or other medical entity to release confidential medical information to Henry Ford Center for Precision Diagnostics concerning my medical history. I authorize Henry Ford Center for Precision Diagnostics to release confidential medical information to my health insurance carrier to facilitate reimbursement of my medical fees.	Cardholder Name:			☐ MasterCard ☐ VISA ☐ Discove	er 🗖 AmExpress	Exp. Date:
I understand Henry Ford Center for Precision Diagnostics may contact my insurance carrier regarding coverage of genetic testing. I authorize the disclosure of insurance benefit coverage and payment information to Henry Ford Center for Precision Diagnostics. I authorize my physician or other medical entity to release confidential medical information to Henry Ford Center for Precision Diagnostics concerning my medical history. I authorize Henry Ford Center for Precision Diagnostics to release confidential medical information to my health insurance carrier to facilitate reimbursement of my medical fees.	Cardholder Signature:			Card Number:		CVC #:
Signature of Patient or Guardian: /	I understand Henry Ford Center for Pr insurance benefit coverage and paym release confidential medical informati	recision Diagnos nent information t ion to Henry Ford	tics may contact my insura to Henry Ford Center for F d Center for Precision Diag	nce carrier regarding coverage of c Precision Diagnostics. I authorize my gnostics concerning my medical his	y physician or ot tory. I authorize	her medical entity to Henry Ford Center for
	Signature of Patient or Guardian:				Date:	//

Printed name of Patient or Guardian:

_ Date: ____