313.916.4DNA (4362)
Toll Free: 855.916.4DNA
Fax: 313.916.7071
www.henryford.com/hfcpd

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

Name: _____ Gender: M F

MRN: _____ DOB: _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's Email Address: _____

Patient's Primary Phone #: _____

Patient's primary language if not English: _____

Ordering Physician Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email Address: _____

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)

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 Prior Authorization #: _____

Insurance Co. phone number: _____

Insurance Co. Fax number: _____

Secondary Insurance Information

INSURANCE BILL (include copy of both sides of insurance card)

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 Prior Authorization #: _____

Insurance Co. phone number: _____

Insurance Co. Fax number: _____

PATIENT BILL

CHECK PAYMENT (make check payable to Henry Ford Center for Precision Diagnostics | Attach check to this form) Amount $: _____

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: _____ ❑ MasterCard ❑ VISA ❑ Discover ❑ AmExpress Exp. Date: _____

Cardholder Signature: _____ Card Number: _____ CVC #: _____

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.

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

Printed name of Patient or Guardian: _____ Date: _____ / _____ / _____