IGeneX Inc.

FOR MEDICARE PATIENTS ONLY

BD-F-022v8 05-01-2024

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MEDICARE PATIENT INSURANCE INFORMATION

Please include a copy of the front and back of patient's insurance card(s)

Last Name	First Name	Middle
MEDICARE Number	PART B COVERAGE Effective Date: _____ / _____ / _____	

Please check one of the following:

- ❑ Medicare is my Primary Insurance
- ❑ Medicare is my Secondary (Supplemental) Insurance
  (Please complete the Primary Insurance Information Section below)
- ❑ I have Medicare as Senior Advantage Plan
  (Please complete the Senior Advantage Information Section below)

PRIMARY INSURANCE INFORMATION

Primary Insurance Carrier ❑ HMO ❑ PPO	Policy ID	Group ID
Primary Insured's Name	Relationship to Insured ❑ Child ❑ Spouse ❑ Self ❑ Other _____	
Primary Insurance Phone Number: ( ) -	Claim Remit Address	

SENIOR ADVANTAGE PLAN INFORMATION

IGeneX, Inc. is not an in network provider with any Medicare Senior Advantage Plan.
For Senior Advantage Plans that are classified as HMO, PPO, or Direct,
IGeneX, Inc. is considered an out of network provider.

Insurance Carrier ❑ HMO ❑ PPO	Policy ID	Group ID
Insured's Name	Relationship to Insured ❑ Child ❑ Spouse ❑ Self ❑ Other _____	
Insurance Phone Number: ( ) -	Claim Remit Address	

Please note, reimbursement from your Medicare Senior Advantage Plan for our services may be reimbursed at an out of network level or may have a denial of payment for services.

Please choose one of the following options, sign, and date your choice:

- ❑ Option 1 **Yes, I want to receive these services.**
  I understand that my Senior Advantage Plan may not reimburse for these services or may reimburse at an out of network level. I will be responsible for any amounts not covered by my Senior Advantage Plan.
- ❑ Option 2 **No, I have decided not to receive these services**
  I will consult this matter with my physician.

_____	_____	_____
Print Name	Patient Signature (Required)	Date

Referring Physician: _____

REMINDER: Please review, complete, and sign attached Advanced Beneficiary Notice of Coverage (ABN) if any of the cePCR (Culture enhanced) tests or panels are ordered.

NOTE: Your Healthcare information will be kept confidential. Any information that we collect about you on this form will be kept in our office. If a claim is submitted for you, this form may be shared with your Senior Advantage Plan carrier. Your information will be kept confidential with your Senior Advantage Plan carrier.