IGeneX Inc.

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Courtesy
Third Party Insurance Claim Submission
Use Only

BD-F-010v2 10-15-2019

COURTESY THIRD PARTY INSURANCE CLAIM SUBMISSION

IGeneX provides services to you on a direct payment basis, and does not accept any form of third party insurance. We can process your out-of-network claim submission for you with insurance companies listed below as a courtesy.

Please note:

- We are NOT an in network provider and do not accept insurance reimbursement
- You will need to prepay for your services rendered at IGeneX at the time the specimen is sent. We accept Visa, MasterCard, Discover, American Express, Personal Checks or Money Orders
- We will perform a courtesy out-of-network claim directly with your insurance company
- We will NOT follow up with YOUR insurance company on claim status, denials, perform any appeals or forward claims to your secondary insurance company. That is your responsibility
- We cannot file claim(s) on behalf of the patient for services provided by your referring physician
- In cases where the insurance company sends explanation of benefits and/or reimbursement to IGeneX, we will reimburse the amount received
- If we are unable to bill your insurance we will inform you so you may file the claim yourself
- Be sure your referring physician has provided the appropriate diagnosis code(s) on test requisition form
- If your insurance company is not listed, please check our website at www.igenex.com for an up-to-date list

If you would like us to submit your claim to your insurance on your behalf, please provide a copy of the front and back of your insurance card and complete the following required fields to properly file insurance claims:

THIRD PARTY INSURANCE INFORMATION

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

Patient's Last Name	Patient's First Name	Middle Initial

Patient's Date of Birth	Gender	Relationship to Insured
MM / DD / YYYY	❑ Male ❑ Female	❑ Child ❑ Spouse ❑ Self ❑ Other _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Carrier ❑ HMO ❑ PPO	Policy ID Number	Group ID Number

Primary Insured's Last Name (if different from patient)	Primary Insured's First Name (if different from patient)	Middle Initial

Insured's Date of Birth	Insured's Gender	Primary Insurance Carrier's Telephone
MM / DD / YYYY	❑ Male ❑ Female	( )

Primary Insurance Claim Submission Address:	City	State	Zip Code

I authorize IGeneX to release information received including, without limitation, medical information, which includes laboratory test results, to my health plan/ insurance carrier and its authorized representatives. I understand IGeneX will be filing an out-of-network claim to my insurance company on my behalf. I further understand my health plan/ insurance carrier may not approve and reimburse for testing in full due to coverage limits, benefits exclusions, lack of authorization, medical necessity or otherwise. My signature indicates I acknowledge and accept financial responsibility for all services rendered at IGeneX Reference Laboratory.

_____	_____	_____
Insured's or Authorized Person's Signature	Print Name	Today's Date

If your health insurance company is not listed below, it means IGeneX is currently not contracted as an out-of-network provider with your health insurance company and cannot process out-of-network claim submission on your behalf. A statement of payment including the cost of each procedure will be mailed to patient or responsible party. Please submit the statement to your health insurance carrier for possible reimbursement based upon your plan coverage.

AARP
Aetna
Aetna Better Health (LA, MO)
Alliant HP of GA
Amerihealth Cartias - UHC
Amerihealth Cartias PA
Amerihealth Caritas VIP MI
Amerihealth Caritas DC
Banner Health - AZ
Blue Cross
Blue Cross Blue Shield
Blue Shield
CBA Blue
Cigna Healthcare
Cigna Healthsprings Bravo
CoreSource (AZ, IL, MD)
CoreSource (MN, NC, PA)
Empire Blue Shield NY
Gateway HP AA
GEHA
HealthChoice AZ
Healthpartners MN
HealthSmart Benefits Solutions - WV
Humana
Mercy Care AZ
People Health Networks - MS
Secure HP - CA
UnitedHealthcare
VAPCC 1 2 4
Wausau

NOTE: Your Healthcare information will be kept confidential, any information that we collect about you on this form will be kept in our office.