HENRY FORD HEALTH
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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.

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: _____ / _____ / _____