

Payment Form

Patient Name	_____			Accession Number (internal use)
	First	MI	Last	
Institutional Billing				
Institution Name	_____			Client Authorization # _____
Billing Contact	_____			Phone (____) _____
Billing Address	_____			Fax (____) _____
	Number	Street	Bldg/Ste	e-mail _____
	City		State	Zip _____

Commercial Insurance¹ Billing

Correlagen has established the Capped Patient-Payment Plan (CPPP) to assist patients covered by most commercial insurance. The CPPP limits the financial responsibility of the patient to 15% of the total cost plus any portion of the test cost that is applied by the insurance company to the patient's annual deductible. To participate in the CPPP, patients must be pre-qualified prior to testing (contact a Client Services Representative to get pre-qualified). Once pre-qualified, patients need to complete the information below and provide the 15% payment before testing is initiated. Patients choosing not to participate in the CPPP will be responsible for all charges not covered by their insurance carrier within 60 days of claim submission. Note: a higher CPPP rate applies for family testing. See <http://www.correlagen.com/resources/billing.jsp> for CPPP details and exceptions.

¹Commercial insurance does not include programs such as Medicare, Medicare HMOs, Medicaid, or Tricare/Champus.

Subscriber Name	_____		Relationship to Patient	_____
	First	Last		
Insurance Carrier	_____		Subscriber Date of Birth	____/____/____ month day year
Membership ID #	_____		Group/Policy #	_____
Claims Mailing Address	_____		ICD-9 code	_____
	Number	Street	Bldg/Ste	
	City		State	Zip _____
Phone	(____) _____	Fax	(____) _____	

****Please include a copy of both sides of the insurance card (required).****

Authorization to Release Information and Pay Benefits: I authorize Correlagen Diagnostics, Inc., to release all information necessary for reimbursement to my designated insurance carrier. I authorize that benefits under this claim be paid directly to Correlagen Diagnostics and will remit any insurance payments that I receive to Correlagen. I acknowledge responsibility for 100% of the service price if I fraudulently represent insurance. In the event of underpayment or denial by my insurance carrier, I authorize Correlagen or its designee to appeal on **my behalf**² to overturn the denial or receive reimbursement for the underpaid claim.

²Correlagen and/or its designee may perform this appeal on my behalf, but is not obligated to do so.

- I choose to participate in Correlagen's Capped Patient-Payment Plan (please fill out the Check/Credit Card section below)
- I waive the opportunity to participate in Correlagen's Capped Patient-Payment Plan

_____	_____
Patient or Parent/Guardian Signature	Date

Payment by Check/Credit Card (Credit card charges may be applied for self-pay, CPPP co-pays, and any applicable deductibles)

Check or money order enclosed \$ _____

Credit Card Master Card Visa Card Number _____

Name as it appears on card _____ Expiration Date _____

Billing Address _____

Number Street City State Zip

Please bill my credit card for the amount of \$ _____

_____	_____
Signature (required)	Date