Save time by completing this form at www.gdx.net/register

Enter your online confirmation code: _____

OR Refer to the billing options on the front and fill in the required sections below. *(Please use black or blue pen).*

1 Patient Information Section *Required for all patients.*

Full SSN required for insurance billing and online access to your test results.

Patient Date of Birth mm/dd/yyyy: ☐☐ - ☐☐ - ☐☐☐☐ **Sex:** M ☐ F ☐ **Social Security #:** ☐☐☐ - ☐☐ - ☐☐☐☐

Patient Name (last): (first): (middle):

Mailing Address:

City: **State:** **Zip:** -

Cell Phone: **County:** **Country:**

Alternate Phone:

Email:

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Multiracial ☐ Other ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other ☐ Unknown

Responsible Party Name: *(Other legal guardian or if patient is a minor child)*

Name (last): (first): (middle):

If you reside in OH or NH, the following fields are required:

Occupation: _____ Employer Address: _____

Employer: _____ _____

2 Insurance Information Section

List your primary insurance information here. Include copies of all your health insurance cards to ensure accurate claim filing.

(Print clearly)

Insurance Company: _____

Please include front/back copy of all health insurance cards

Claims Address: _____

City/State/Zip: _____

Phone #: _____

Subscriber Name: _____

Subscriber ID #/Medicare #: _____

Group #: _____

Subscriber Date of Birth: (mm/dd/yyyy) _____

Relation to Patient: ❑ Self ❑ Spouse ❑ Other _____

Please note: We do not participate with Medicaid. All Medicaid patients should use the no insurance option.

3 Payment Section *For Bill Insurance / No Insurance.*

Visit www.gdx.net/pay for additional details and to make your payment online!

Bill Insurance Option

If choosing to have us bill your commercial insurance or Medicare Advantage plan, **you do not need to include a payment at this time.**

We will bill a claim to your insurance and you will receive a statement if there is an amount due.

Payment from: ❑ Practitioner ❑ Patient

Payment type: ❑ Payment online: *(Patient only)* **www.gdx.net/pay** 6-Digit Confirmation Code

❑ Check #_____ Amount: $_____

Make checks payable in US dollars to Genova Diagnostics

❑ Credit Card Authorized Amount: $ _____

(Print clearly)

Credit Card #:

Background color is for security purposes

Expiration Date: ____/____ CVV: _____

Cardholder Signature: _____

Printed Name: _____

Card Holder's Billing Zip Code: _____

For more payment information, visit our website: **www.gdx.net/pay**. Your practitioner will also have the payment information on their lab fee schedule.

No Insurance Option (Cash Pay)

If you are not using insurance, please complete the payment section to the right and provide the cash price for this test.

We will provide an insurance ready receipt upon completion of your test.

4 Patient/Responsible Party Acknowledgement *Please read and sign below.*

I have read the Billing Guidelines and I understand my responsibilities as described within them.

Except in the case of pre-payment I authorize the payment of all medical benefits to be paid directly to Genova Diagnostics and authorize the release of any medical information required for my health plan to process/pay claims resulting from my testing services. I understand that the tests listed on the front of this form may be out of network for my health plan and acknowledge my financial responsibility per my plan benefits and according to the applicable billing guidelines. If Genova Diagnostics participates with my health plan: 1) I acknowledge that payment will be applied toward the patient responsibility after my health plan has processed the claim, and 2) I understand that the tests on the front of this form may be deemed not medically necessary, experimental, or investigational by my health plan and authorize the services to be performed and to be financially responsible for the cash price described in the company's fee schedules.

Medicare Patients should refer to the Advanced Beneficiary Notice document in the collection pack (if applicable) related to medical necessity for certain tests.

I authorize Genova Diagnostics to act as my representative in any claim appeal process. I permit a copy of this requisition to be used in place of the original.

Under the General Data Protection Regulation (GDPR) issued by the European Commission, Genova Diagnostics is a third-party processor of that Customer Personal Data; the above signed Practitioner/Clinician is a controller and/or processor, as applicable, of that Customer Personal Data under the European Data Protection Legislation; and each party will comply with the obligations applicable to it under GDPR Legislation with respect to the processing of that Customer Personal Data. Genova Diagnostics is permitted to process Customer Personal Data only in accordance with applicable law: (a) to provide the services as designated above and related technical support; (b) as further specified via Customer's use of the Services; (c) as documented in the form of the applicable Agreement, including this Data Processing Amendment; and (d) as further documented in any other written instructions given by Customer and acknowledged by Genova Diagnostics as constituting instructions for purposes of this Data Processing Amendment. The customer should contact the provider of record for details regarding the scope of processing agreement and subject's personal data rights.

Patient/Responsible Party Name: _____ Date: _____

Signature (required): _____

QUESTIONS? 1-800-522-4762

5 Visit Your Patient Resource Center

• Access test results • Make payments • Complete health surveys

Log On At: **www.gdx.net/prc**

GENOVA DIAGNOSTICS | 63 Zillicoa Street Asheville, NC 28801 | 800.522.4762 www.GDX.net

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