



## Billing Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### Please indicate method of payment below:

Private insurance     Institutional billing (for Medicaid patients only)     Self pay

### Private Insurance

*Please complete the following section and attach a copy of the patient's insurance card (front and back) if private insurance is checked above.*

Insurance Company Name: \_\_\_\_\_ Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Relationship to Insured:  Self  Spouse  Child  Other

Patient Signature: \_\_\_\_\_

### Institutional Billing

*Please complete the following section if institutional billing is checked above. Institutional billing is available for Medicaid patients only.*

Institution Name: \_\_\_\_\_

Department or Division: \_\_\_\_\_

Authorized Agent: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Agent Signature: \_\_\_\_\_

### Self Pay

The total cost of the analysis must be included with the sample and requisition. We accept checks, money orders, and credit cards (MC, Visa, AMEX, and Discover) as methods of payment. If patient opts to pay by credit card, please attach a copy of the credit card and have the patient sign below.

I agree to pay the total cost of the analysis to Northwestern Reproductive Genetics, Inc.

Patient (sign) \_\_\_\_\_ (print) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_