Diagnos-Techs, Inc.
Clinical & Research Laboratory
PO Box 389662
Tukwila, WA, 98138-9662

Lab Use Only

Insurance Billing Information

FILL PRIMARY CARRIER INFORMATION COMPLETELY.
FILL SECONDARY CARRIER INFORMATION IF APPLICABLE.

PRIMARY Carrier Information

Subscriber Information:

Subscriber ID:

Group Number:

First Name: M.I. Last Name: Date of Birth / /

Employer Name:

Patient's Relationship to Subscriber: ○ **Self** ○ **Spouse** ○ **Child** ○ **Other**

Insurance Co. Information:

Name:

Address:

City, State, ZIP:

Phone #: -

SECONDARY Carrier Information

Subscriber Information:

Subscriber ID:

Group Number:

First Name: M.I. Last Name: Date of Birth / /

Employer Name:

Patient's Relationship to Subscriber: ○ **Self** ○ **Spouse** ○ **Child** ○ **Other**

Insurance Co. Information:

Name:

Address:

City, State, ZIP:

Phone #: -

PATIENT OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim.

Signature: _____ **Date** _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the physician or supplier of the services provided.

Signature: _____ **Date** _____

PATIENT: Your physician has ordered specified tests that he or she has determined to be necessary for your care. Our laboratory will perform these tests and then bill your insurance carrier(s) for these services. However, if your insurance carrier(s) determines that all/part of this test is not covered, the carrier will deny payment. In those cases where the carrier denies coverage, the billing will be forwarded to you and you will be responsible fo payment.

Signature: _____ **Date:** _____

For optimum accuracy, please print in capital letters and avoid contact with the edge of the box.

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N O P Q R S T U V W X Y Z

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