AT THE FOREFRONT UChicago Medicine | Medical Laboratories

BILLING OPTIONS

There are some tests for which we do not offer insurance billing. Please consult our website and quick guide (list of tests, costs, TAT and CPT codes) or contact us for more information.
All samples received with incomplete billing information will delay processing time.
Test canceled while "in progress" will be billed for the amount of work completed up to that point.
Please forward all billing questions to: venessa.gamboa@uchospitals.edu or call 312-213-5441.

Patient Name: *Last* _____ *First* _____ (MI): _____ Date of Birth: _____

1.) Institutional Billing *(Pre-payment is required for all samples referred from outside the US or Canada.)*

Billing Institution: _____ PO#: _____

Financial Contact: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Email (required): _____

2.) Self-Pay

Please provide address and contact information for the entity or individual to be invoiced.

Name: _____

Address: _____

City : _____ ***State:*** _____ ***Zip/Postal Code:*** _____

Phone: _____ ***Email:*** _____

3.) Insurance Billing *(We do NOT accept Illinois or any out-of-state Medicaid. Please note we do not bill insurance for all our testing options. Please see our website for more details. Prices listed on our website are not applicable for insurance billing, please contact us for insurance pricing information.)* *A legible photocopy of the front and back of the insurance card and insurance authorization must be included.*

ICD-10 Diagnosis Code(s): _____ ***(Must be provided or insurance cannot be filed.)***

Policyholder Name: _____ Date of Birth: ____/____/_____ Sex: ☐ Male ☐ Female

Policyholder Address: _____ City: _____ State: _____ Zip: _____

Relationship to the Patient: ☐ Self ☐ Spouse ☐ Dependent ☐ Other Preauthorization # (*if applicable*): _____

Name of Primary Insurance: _____ Policy No. _____ Group No.: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

PCP/Referring Physician Name: _____ NPI #: _____

Name of Secondary Insurance: _____ Policy No.: _____ Group No.: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

The policy holder's signature to the following statement: I hereby authorize any physician who treated or attended to me or my dependent(s) to furnish any medical information requested. In consideration of services rendered, I hereby transfer and assign to the University of Chicago Genetic Services Laboratories any benefits of insurance I may have. I assume responsibility for the balance of the cost of testing not paid by my insurance company. A photocopy of this authorization shall be considered as effective and valid as original.

Authorized Signature: _____ Date: ____/____/_____