AVELLINO Laboratories
DNA is Life

SUPPLEMENTARY INSURANCE FORM

Patient Information

Patient Identification No:	Medical Records No:	Test Requisition No: ALU _____

Patient First Name: MI: Last Name:

Patient Street Address: Suite/Apt:

City: State: Zip Code:

Referring Provider's Information

Referring Provider's Name:	Referring Provider's NPI:

Insurance | Payment Details

☐ A copy of the front and back of the insurance card is attached.
☐ Insurance information is listed below:

Insurance Name:

Member/Subscriber Name:

Member/Subscriber ID: Group Number:

Diagnosis Information

- ☐ H17.10 Central corneal opacity, unspecified eye
- ☐ H17.11 Central corneal opacity, right eye
- ☐ H17.12 Central corneal opacity, left eye
- ☐ H17.13 Central corneal opacity, bilateral eye
- ☐ H17.811 Minor opacity of cornea, right eye
- ☐ H17.812 Minor opacity of cornea, left eye
- ☐ H17.813 Minor opacity of cornea, bilateral eye
- ☐ H17.819 Minor opacity of cornea, unspecified eye
- ☐ H17.89 Other corneal scars and opacities
- ☐ H17.9 Unspecified corneal scar and opacity
- ☐ H18.50 Unspecified hereditary corneal dystrophies
- ☐ H18.53 Granular corneal dystrophy
- ☐ H18.54 Lattice corneal dystrophy
- ☐ H18.59 Other Hereditary corneal dystrophies
- ☐ Other Diagnosis Codes

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Patient Consent/Authorization

I request and authorize the performance of the designated test(s) on the DNA sample provided by me. My signature below constitutes my acknowledgement that I have been informed of the benefits and limitations of this testing which have been explained to my satisfaction by a qualified healthcare professional.

Assignment of benefits: I hereby authorize the entity to bill the insurance company and receive payment from them on my behalf. I acknowledge, however, that I am responsible for payment of my account and any and all charges associated with its collection. I hereby authorize my insurance company to pay the entity directly for the services rendered.

Appeal Authorization: In the event of an underpayment or denial by my insurance carrier, I hereby authorize the entity or their designee, to appeal on my behalf to provide the actions and information necessary to overturn the denial or receive reimbursement for the underpaid claim. This authorization shall remain valid until the charges for the orders on this form are paid in full.

Donor Signature: I certify that I provided my specimen to the collector; that I have not adulterated it in any manner, each specimen used was sealed in my presence; and that the information provided on this form and on the label affixed to each specimen is correct. I authorize the release of the results to the ordering clinician, authorized client/representative, or prescribing/attending physician. I authorize the entity to release any information required for billing purposes. I understand that I am responsible for payment of any deductibles or co-insurance charges. I also agree that in a case where my insurance provider sends payment directly to me, I will endorse the insurance check and forward to the entity within 30 days. I understand that all personal health information will be treated confidentially, in accordance with applicable state and federal law, where such practices and rights concern personal health information. I have read, understand, and agree to the informed consent above and the test services being performed.

Patient/Guardian Signature	Date

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