IGeneX Inc.
795 San Antonio Road | Palo Alto | CA 94303-4801 | T: (800) 832-3200 | F: (650) 424-1196 | www.igenex.com

FOR MEDICARE PATIENT ONLY

BS-F-049 REV.001 07-15-16

MEDICARE PATIENT INSURANCE INFORMATION

Please include a copy of the front and back of patient's insurance card(s)

Last Name	First Name	Middle

MEDICARE Number	PART B COVERAGE Effective Date: _____ / _____ / _____

Please check one of the following:

- ❑ Medicare is my Primary Insurance
- ❑ Medicare is my Secondary (Supplemental) Insurance
  (Please complete the Primary Insurance Information Section below)
- ❑ I have Medicare as Senior Advantage Plan
  (Please complete the Senior Advantage Information Section below)

PRIMARY INSURANCE INFORMATION

Primary Insurance Carrier ❑ HMO ❑ PPO	Policy ID	Group ID

Primary Insured's Name	Relationship to Insured ❑ Child ❑ Spouse ❑ Self ❑ Other _____

Primary Insurance Phone Number: ( ) -	Claim Remit Address

SENIOR ADVANTAGE PLAN INFORMATION

IGeneX, Inc. is not a provider with any Medicare Senior Advantage Plan. IGeneX is a provider with regular Medicare. Senior plans that are HMO, PPO, or Direct, IGeneX, Inc. are considered an out of network provider.

Insurance Carrier ❑ HMO ❑ PPO	Policy ID	Group ID

Insured's Name	Relationship to Insured ❑ Child ❑ Spouse ❑ Self ❑ Other _____

Insurance Phone Number: ( ) -	Claim Remit Address

Please note, reimbursement from your Medicare Senior Advantage Plan for our services may be reimbursed at an out of network level or may have a denial of payment for services.

Please choose one of the following options, sign, and date your choice:

- ❑ Option 1 **Yes, I want to receive these services.**
  I understand that my Senior Advantage Plan may not reimburse for these services or may reimburse at an out of network level. I will be responsible for any amounts not covered by my Senior Advantage Plan.
- ❑ Option 2 **No, I have decided not to receive these services**
  I will discuss this matter with my physician

_____	_____	_____
Print Name	Patient Signature (Required)	Date

Referring Physician: _____

REMINDER Please review, complete, and sign attached Advanced Beneficiary Notice of Coverage (ABN) if any of the following test(s) is ordered: **Test#275 CD57**

NOTE: Your Healthcare information will be kept confidential, Any information that we collect about you on this form will be kept in our office. If a claim is submitted for you this form may be shared with your Senior Advantage Plan carrier. Your information will be kept confidential with your Senior Advantage Plan carrier.