Baylor Miraca Genetics Laboratories

Patient Insurance Benefit Verification Form

TEL 713.798.3566 **FAX** 713.798.4187
www.bmgl.com billing@bmgl.com

INSTRUCTIONS

1. Complete all ▸**REQUIRED** sections below.
2. Fax or email this form with a copy of the front and back of your insurance card.

If a prior authorization or pre-determination is required by the patient's insurance plan, we will ask you for additional information such as clinical notes and a letter of medical necessity. Please allow one business day for a response from a dedicated billing representative. If you do not receive a timely response, please notify the billing manager at **billing@bmgl.com.**

▸ PATIENT INFORMATION

Last Name | First Name | MI

Address

Date of Birth (MM/DD/YY) ○ Male ○ Female

City | State | Zip

▸ REFERRING INFORMATION

Ordering Physician Name | NPI#

Address

Practice Name | Phone | Fax

City | State | Zip

▸ GENETIC COUNSELOR

Name | Email

Phone | Fax

▸ GENETIC TEST INFORMATION

Specify All Tests ordered - Provided Test Code(s) and Test Name(s)

Specify all applicable ICD-10 codes with Diagnosis

PATIENT INSURANCE INFORMATION

REQUIRED IF FRONT AND BACK COPY OF PATIENT'S INSURANCE CARD OR FACESHEET IS NOT AVAILABLE.

Policyholder Name | Relationship to Patient

Company Name | Address

ID Number | Group Number

City | State | Zip

Authorization Number (If Obtained)

Phone | Fax