US Reimbursement Request Form

Patient

Surname: _____

First name: _____

Date of birth: _____

Sex: ☐ male ☐ female ☐ unknown

Patient address: _____

_____

_____

_____

Patient telephone #: _____

Patient email: _____

Insurance company: _____

Insurance policy #: _____

Please send a copy of front and back of insurance card together with this form.

ICD-10 diagnosis codes _____

Patient acknowledgment:

My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to CeGaT and for CeGaT to release the results of the testing to the ordering physician. I authorize CeGaT to submit a claim for payment along with any required information for purposes of collecting payment from my insurance provider including Medicare. I understand if my insurance provider remits payment directly to me, I am to forward said payment directly to CeGaT I understand that I am responsible for any and all charges not covered by my insurance provider, including any deductible, copayment or coinsurance as directly by my health insurance carrier.

_____ _____

Patient / Legal Guardian **Physician**

X _____ **X** _____

Patient / Legal Guardian **Physician**
(Date, Signature) (Date, Signature)

Sender / Clinic / Ordering Provider

Surname: _____

First name: _____

Institution: _____

NPI #: _____

Notes

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CeGaT on this page refers to both these entities:
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