South Bend Medical Foundation
530 North Lafayette Boulevard
South Bend, IN 46601-1098

Third-Party Billing Request

Billing – Patient Accounts Queue: 1-800-937-7263 Ext 5990

Please respond back to Client Accounts at FAX NUMBER: (574)-807-3044

DATE: _____ **PAGES:** _____

(INCLUDES COVER SHEET)

We have determined that this Molecular Pathology or Advanced Diagnostic Laboratory Test is medically necessary for patient diagnosis or treatment. It also meets all other criteria for the Laboratory DOS exception policy as set forth in CY 2018 OPPS. I acknowledge genetic testing is often subject to prior authorization requirements. If prior authorization is required, I am responsible to provide proof before charges will be transferred. Although traditional Medicare does not require prior authorization, many advantage plans do. I am requesting charges to be transferred to the patient's Medicare plan and have filled out this form or have attached supporting documentation

Client Name	Hospital Outpatient Collection – Molecular Pathology Testing
Client Account Number	
Accession Number	
Test Name	
Order Codes or CPT if known	

Patient Information

Patient Name (Last, First)		
Service Date (Collection Date)		
Patient's Birth Date (Month, DD, YYYY)		Gender ☐ Male ☐ Female
Diagnosis Code (ICD10)		
Ordering Physician (Last, First)		
Physician's National Provider I.D. (NPI)		
Subscriber's Name (If Different than Patient)		Relationship to Patient ☐ Dependent ☐ Spouse ☐ Other
Patient's Street Address		
City	State	Zip Code

Insurance Information

Medicare HIC Number (If Applicable)		
Medicaid Number (If Applicable)		
Insurance Company's Name (If Applicable)		
Insurance Company's Street Address		
City	State	Zip Code
Policy Number		
Group Number		
Prior Authorization Required: ☐ Yes ☐ No	Prior Authorization Number if Yes	