



GeneDx, Inc.

207 Perry Parkway
Gaithersburg, MD 20877
Phone 301-519-2100
Fax 301-519-2892
E-mail: genedx@genedx.com
Web site: www.genedx.com

PAYMENT OPTIONS

1. Payment by credit card: The *full amount* of the test fee is charged at the time of sample submission.

Name as it appears on card _____

Billing address _____

Mastercard

Visa

Discover

_____ City, State

_____ Zip code

American Express

Account Number | | | | | | | | | | | | | | | | | | | | | |

Expiration date: Month ____ / Year ____

Please bill my credit card in the amount of \$ _____ for
diagnostic laboratory tests performed by GeneDx, Inc.

_____ (Required)

Signature

2. Payment by check or money order: Minimum of 75% of the cost of the test is required at the time of sample submission*, with the remainder of the fee billed at the time of test completion.

Check or money order enclosed in the amount of \$ _____

3. Institutional Billing: The hospital laboratory or referring physician can be billed.

Please attach a letter stating the name of the contact person, address to which bill should be submitted, phone # and fax #. Call 301-519-2100 with questions.

4. GeneDx does not bill insurance companies directly unless all of the following is submitted:

- Credit card information (complete part 1) to which any outstanding balance will be billed;
- An authorization number or letter of agreement from the insurance company. The letter of agreement should be directed to GeneDx and detail the reimbursement rate, the name of the department or individual to whom the bill will be sent (including address, phone and fax numbers) and the patient's name and policy number.
- Copy of both sides of the insurance card.

I UNDERSTAND THAT I AM RESPONSIBLE IN ALL CASES FOR ALL FEES NOT COVERED BY INSURANCE. _____ signature (required)

Note: If **you** plan to apply to your insurance carrier for reimbursement of **your** expenses for this test, the following information may be helpful in the case that GeneDx is requested by the carrier to prepare supporting documentation for you to use in your insurance claim:

Insurance carrier _____

Is this a Blue Cross/Blue Shield Plan? YES NO

Subscriber Name _____

Is this a Medicaid plan? YES NO

Subscriber DOB ____ / ____ / ____ ID# _____

For patients from outside the United States, 100% of the fee is due at the time of sample submission