*Please consult our referral email policy.

WHY YOU MAY RECEIVE A BILL

- **Insufficient insurance information or no insurance provided.**
- **No response from your insurance company.** When this happens, it is your responsibility to resolve this matter with your insurance company.
- **Co-insurance, co-payment, or deductible.** This is the amount due from you as determined by your insurance plan. Please contact your insurance for your plan benefits.

Any disputes with your insurance company involving participating providers, coverage, eligibility or unpaid balance will be your responsibility.

BILLING POLICY

Please attach a copy of the front & back of your insurance cards so we can process your insurance coverage accordingly.

Our laboratory services are usually considered a medical benefit. Subsequently, we can bill your medical insurance.

If your medical insurance requires a referral for laboratory services, please contact your primary care physician.

Statements will be mailed to you every month to show all activities on your account, until your balance is paid in full.

DUE UPON RECEIPT

All charges are due and payable upon receipt of statement. Your account is past due if not paid by the end of the month, unless your insurance is being actively billed. If you are unable to pay the entire balance, please contact our office immediately to discuss payment arrangements.

A fee of $25.00 will be assessed for any returned checks.

PRIMARY	Medical Insurance	
	Subscriber's Name	Patient's Relationship to Subscriber
	Medical Insurance NAME, Claim filing ADDRESS and PHONE or write "N/A" if NONE	
	Insurance ID number* **(Mandatory)**	
	Subscriber's Birth Date (if not patient)	Insurance Group No.

SECONDARY	Medical Insurance	
	Subscriber's Name	Patient's Relationship to Subscriber
	Medical Insurance NAME, Claim filing ADDRESS and PHONE or write "N/A" if NONE	
	Insurance ID number* **(Mandatory)**	
	Subscriber's Birth Date (if not patient)	Insurance Group No.

ASSIGNMENT OF BENEFITS

I understand the billing policy and I authorize the release of any medical, dental, or other information to process this claim. I also authorize payment of government benefits and my insurances to make any payments directly to the University of Washington, Oral & Maxillofacial Pathology Service, for laboratory services provided.

Signature of insured or authorized person REQUIRED **Date**

* PRIVACY ACT STATEMENT: We require your Social Security Number on this form to ensure compliance with your insurance company's claim filing procedures. If your insurance uses a different number as your identification number we do not require you to disclose your Social Security Number.