*Please consult our referral email policy.

WHY YOU MAY HAVE RECEIVED 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 completely fill out the form below, so we can process your insurance coverage accordingly. ***Alternatively, you may send in a copy of the front & back of your insurance cards.***

Our laboratory services are usually considered a medical benefit unless the surgery work performed was dental in nature. Subsequently, we can only bill either the medical or dental insurance, not both.

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.

ACCOUNT QUESTIONS

Local:	206-616-1359
Toll Free:	800-617-8674
Fax:	206-543-8054
E-mail:	omps@uw.edu
Hours:	8:15 AM – 4:45 PM, M-F

Patient Name _____

MEDICARE	PLEASE ATTACH COPY OF CARD	Patient's Birth Date	DSHS-MEDICAID	Provider One Number

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

RESET FORM