



Patient/Recipient Information

Patient full name:

Date of Birth:
month day year

Sex:

Social Security Number:

Parent/Guardian:
(if applicable)

Address:

City: **State:** **ZIP/Postal Code:**

Email:

Day Phone:

Alternate Phone:

Fax:

Emergency Contact Name:
(not living at above address)

Emergency Contact Phone:

Referring Physician Information

Primary Care Physician:

Address:

City:

State:

ZIP/Postal Code:

Phone:

Do You Have Medicare Coverage?

YES NO

Medicare Number:

Primary Insurance Carrier *(complete all that apply)*

Insurance Company:

Address:

(from card)

City:

State:

ZIP/Postal Code:

Phone:

Group Plan No.:

Member Name:

Policy No.:

Secondary Insurance Carrier (if any/complete all that apply)

Insurance Company:

Address:

(from card)

City:

State:

ZIP/Postal Code:

Phone:

Group Plan No.:

Member Name:

Policy No.:

Please be aware that all medical information is confidential under certain state and federal laws. Such information may not be released without your consent. Many insurance carriers require medical information to be submitted with claims to evaluate medical necessity. Please provide your written consent to release related information when required or requested to your insurance company(s), Medicare and/or your healthcare provider.

AUTHORIZATION

I, , do hereby authorize Everist Genomics, Inc or any of its subsidiaries, to acquire from and/or release to my healthcare provider and/or my insurance company(s and/or Medicare), any information required for the purposes of provision of the OncoDefender CRC Test and/or for processing all medical claims on my behalf. I authorize Everist Genomics to submit claims to my insurance company or Medicare on my behalf, and my insurance company or Medicare to pay benefits directly to Everist Genomics. Should any insurance or Medicare payment be made directly to the insured for monies due relating to the provision of the OncoDefender CRC Test, I agree to immediately pay over these funds to Everist Genomics. I will be informed of my insurance or Medicare coverage and estimated out-of-pocket expense prior to the provision of the OncoDefender CRC Test or any bills being incurred or sent.

Signature _____ Date _____