BCM-MEDICAL GENETICS LABORATORIES

PHONE: 800-411-GENE | FAX: 713-798-2787 | www.bcmgeneticlabs.org

FAX TRAF FORM TO:
713-798-2787

TEST REVISION AUTHORIZATION FORM (TRAF)

TO: BCM-MGL Client Services
FAX: 713-798-2787
PHONE: 800-411-GENE (4363)
EMAIL: genetictest@bcm.edu

FROM: _____
DATE: _____
#PAGES: _____

IMPORTANT REMINDERS

For Add-on Test:

1. If Ordering Physician has changed, a NEW REQUISITION FORM IS REQUIRED. Please note, the "Add-on Test" request MUST include a signature authorization from the party to be billed.
2. If patient sample was initially handled by your Send-out Department, this add-on request will need to originate from the same Send-out Department.
3. Client Services will contact you once the test is added. If you do not hear from us within 24 hours of submission of this form please contact us at 1-800-411-GENE.

For Cancellation:

1. Cancellation requests are processed only if Acceptable Cancellation Documentation is received before 5 pm the next business day from the day of sample receipt. Cancellation requests received after this time will not be accepted.

PATIENT INFORMATION & REQUEST

*LAST NAME: _____ *FIRST NAME: _____ ACC#: _____

*DATE OF BIRTH (MM/DD/YY): _____ BCM LAB#: _____ FAMILY#: _____ MR#: _____

*PLEASE SPECIFY:

☐ ADD-ON TEST

☐ CANCELLATION

*REQUIRED FIELDS

SPECIFY REQUEST IN BOX (REQUIRED):
1. TEST CODE
2. TEST NAME
3. If sequential testing is requested, specify the testing sequence

ADDITIONAL INFORMATION (such as new accession number):

CONTACT INFORMATION & SIGNATURE OF AUTHORIZATION
(ALL FIELDS ARE REQUIRED TO PROCESS REQUEST)

Name: _____ Institution: _____

Phone#: _____ FAX#: _____ E-mail: _____

Approved by: Print Name: _____ Institution: _____

Signature: _____ Date: _____

BILLING INFORMATION

☐ Check here if billing information is the same as the original test request. If billing information is different, please fill out second page and submit with add-on request.

Note: Please notify your appropriate lab personnel if testing added is to be billed institutionally.

LAST UPDATED: 8/2014

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BILLING INFORMATION

IMPORTANT NOTICE: ONE OF THE THREE FOLLOWING BILLING OPTIONS MUST BE INDICATED BELOW.
PLEASE FORWARD ALL BILLING QUESTIONS TO: MEDGENBILLING@BCM.EDU

PATIENT INFORMATION

PATIENT NAME (LAST,FIRST, MI): _____ PATIENT DATE OF BIRTH (MM/DD/YY): _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ EMAIL: _____

☐ PAYMENT OPTION 1 - INSTITUTION

INSTITUTION NAME: _____ INSTITUTION CODE: _____

CONTACT NAME: _____ EMAIL (REQUIRED): _____

BILLING ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ FAX: _____

☐ PAYMENT OPTION 2 - SELF-PAY (PAYMENT MUST ACCOMPANY SAMPLE)

☐ CREDIT CARD (PLEASE SELECT ONE): ◯ AMEX ◯ DISCOVER ◯ MC ◯ VISA

VALID CARD #: _____ EXPIRATION DATE (MM/YY): _____ CVC CODE: _____

BILLING ADDRESS: _____ CITY, STATE, ZIP: _____

CARDHOLDER PRINTED NAME: _____ CARDHOLDER SIGNATURE: _____

☐ CHECK/MONEY ORDER: CHECK/MONEY ORDER #: _____ AMOUNT ENCLOSED: _____

☐ PAYMENT OPTION 3 - INSURANCE

PROVIDE A LEGIBLE PHOTOCOPY OF THE FRONT & BACK OF THE INSURANCE CARD OR HMO/MEDICAID HMO AUTHORIZATION/REFERRAL.

Please refer to the Financial Policy at www.bcmgeneticlabs.org for complete insurance filing information and managed care contract list. Insurance is filed to our contracted carriers as a client service courtesy. Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. HMO policies must have required approved authorizations. BCM-Medical Genetic Laboratories cannot bill out-of-state welfare programs. We accept authorized Texas Medicaid HMO covered charges for genetic testing. Please contact our office prior to submitting a Texas Medicaid sample. Contact medgenbilling@bcm.edu with questions.

ORDERING PROVIDER: _____

ICD9 Diagnosis Code(s) - must be provided or insurance cannot be filed: _____

◯ PPO, POS, Commercial Insurance - Provide complete member information with legible front & back photocopy of insurance card.

◯ HMO - Provide approved authorization #: _____ and attach legible front & back photocopy of insurance card.

◯ Texas Medicaid HMO - Provide approved authorization #: _____ and contact Billing at 713-798-5849.

INSURED MEMBER'S INFORMATION

MEMBER NAME (Last, First, MI): _____ MEMBER DATE OF BIRTH (MM/DD/YY): _____ GENDER: ◯ FEMALE ◯ MALE

MEMBER POLICY #: _____ MEMBER SS #: _____ MEMBER GROUP #: _____

INSURANCE CO. NAME: _____ PHONE: _____

INSURANCE CO. ADDRESS: _____ CITY, STATE, ZIP: _____

I AUTHORIZE BCM-MEDICAL GENETICS LABORATORIES TO FURNISH ANY MEDICAL INFORMATION REQUESTED ON MYSELF, OR MY COVERED DEPENDENTS. IN CONSIDERATION OF SERVICES RENDERED, I TRANSFER AND ASSIGN ANY BENEFITS OF INSURANCE TO BCM-MEDICAL GENETICS LABORATORIES. I UNDERSTAND I AM RESPONSIBLE FOR ANY CO-PAY, DEDUCTIBLES, OR NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. I UNDERSTAND I AM FULLY RESPONSIBLE FOR PAYMENT OF MY ACCOUNT IF THE BCM-MEDICAL GENETICS LABORATORIES IS NOT A PARTICIPANT WITH MY HEALTH PLAN, AND MY HEALTH PLAN DOES NOT FULLY REIMBURSE MY MEDICAL SERVICES DUE TO LACK OF AUTHORIZATION OR MEDICAL NECESSITY.

PRINTED NAME: _____ SIGNATURE: _____ DATE (MM/YY): _____