ACCU | REFERENCE MEDICAL LAB®

1901 East Linden Ave. Suite 4, Linden, NJ 07036 • www.accureference.com • T: (908) 474-1004 • F: (908) 474-0032

Carrier Screening Self-Pay Patient Agreement

Patient's Name (please print) _____

Insured/Guarantor Name *(if different from patient)* _____

Insurance company _____

Member ID Number _____

We are notifying you that your insurance company, _____, may not cover the service(s) described below. The fact that they may not cover a particular service does not mean that you should not receive it. Based on your profile, your healthcare provider recommends this testing.

TEST CODE	DESCRIPTION	PRICE
☐ CARR	CARRIER SCREENING TEST (INCLUDES CFXZ, SMA, FX)	$450.00
☐ CFXZ	CYSTIC FIBROSIS	$250.00
☐ SMA	SPINAL MUSCULAR ATROPHY	$100.00
☐ FX	FRAGILE X SYNDROME PANEL	$100.00

Doctor's Note: _____

Reasons why charges may be denied:

- It is a non-covered item or service, your insurance company will not pay
- The service is considered experimental or for research use and is not covered
- Other (explain): _____

☐ At this time I have no health insurance coverage or lab may be out of network or my insurance company does not pay for the test(s). I understand that I am responsible for paying all the charges for the lab services performed.

☐ I received the self-pay agreement policy from ACCU Reference Medical Lab. I have read and fully understand the information provided to me.

☐ If I have any questions about my charges, statements or balance due, I understand that I many contact **ACCU Reference Mediccal Lab's Billing Department at 908-474-1004.**

Patient signature _____ Date ___/___/___