Benefit Verification Form

REQUEST INFORMATION		
Patient Name:		Date of Birth:
Patient Contact Number:	Patient Email:	Guarantor:
Ordering Physician:	Clinician Phone Number:	Clinician Email:
Test(s) Requested: ☐ Sequencing Only ☐ Del/Dup Only ☐ Sequence & Del/Dup		
ICD Codes:		

INSURANCE INFORMATION	
Primary Insurance Plan/Company:	
Primary Insurance ID #:	Primary Insurance Group #:
Secondary Insurance Plan/Company:	
Secondary Insurance ID #:	Secondary Insurance Group #:

ADDITIONAL INFORMATION

Please include front and back copy of insurance card(s)

Please send us the form by either:

- Fax at 888-316-1232
- Secure email to billing@oxy-genlab.com

We will send results to the contact individual via secure email.
If you have any questions, please contact our office at 770-686-3620