CSS Instructions: using the tab key to navigate, type info into applicable fields below. This red box won't appear in a printed/faxed document.

Substitute Insurance Billing Information/Signature Form

MYRIAD

Dear Physician/Healthcare Provider:
We received a Test Request Form for your patient listed below. Please have them complete and sign this form, which is necessary for us to proceed with this case. Once complete, please fax the form to my attention at 801-584-3615. Thank you.

Other specifics:

To: _____ **Date:** _____

Fax or Email: _____ **Myriad Case Number:** _____

Patient Name: _____ **Patient Services Coordinator:** _____

Patient Date of Birth: _____ **PSC Phone 800-469-7423 Extension:** _____

Billing/Payment Information

Requires patient signature and readable (enlarged) copies of both sides of insurance card(s). If two cards are submitted, indicate which insurance is primary.

Name of Insured: _____ DOB: _____ Insurance ID#/ SSN#: _____

Patient Relationship to Insured (circle): Self Spouse Child Other Authorization/Referral #: _____

I hereby authorize Myriad Genetic Laboratories, Inc. (MGL) to furnish my designated insurance carrier, health plan, or third party administrator (collectively "Plan") the information on this form and other information provided by my health care provider if necessary for reimbursement. I also authorize all benefits of the Plan to be payable to MGL. I understand that I am responsible for any amount not paid by my Plan for reasons including, but not limited to, non-covered and non-authorized services. I understand that if I am responsible for more than $375 coinsurance (excluding unmet deductibles), Myriad will contact me prior to releasing the test. I permit a copy of this authorization to be used in place of the original.

_____ _____ ☐ Copies of insurance cards (required) are included or have already been submitted

Patient/Responsible Party Signature Date