GALAXY™
ADVANCED MICROBIAL DIAGNOSTICS

# Human Health Billing Information

*Form HH135; Revised 6-30-2021*

## Payment Information Required

**Pre-payment is required for all orders (*Excluding Medicare-eligible testing*). Patients are also responsible for rush shipping fees. Test results will be held until payment is received. Samples are stable for up to two weeks in refrigerator after specimen collection and may expire if pre-payment is delayed.**

**For insurance claims, Galaxy Diagnostics will submit a claim on your behalf for potential reimbursement after testing is complete. A copy of the front and back of your insurance card AND ICD-10 code(s) (obtained from your physician) are required for insurance claim submission. Medicare claims also require a completed ABN form for order processing.**

## Pre-Payment Information

Visa / Mastercard / Amex / Discover  Exp __ __/__ __ (mm/yy)  CSV __ __ __  Billing zip code _____

Name on card _____  Card # __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Signature _____  **How did you hear about us?** _____

## Claims Filing Patient Identification

*Please select one of the billing options below*

### ❑ Self- Pay (no insurance to be filed)

Please choose this option if uninsured or would not like a reimbursement claim submitted on your behalf.

**Some test options are self-pay only**. This is because specific insurance coding is not currently available due to the use of unique sample enrichment technology. **The following test options are not eligible for private insurance/ Medicare reimbursement:**

- ***Bartonella* Digital ePCR™**
- ***Bartonella spp* ddPCR**
- **Lyme *Borrelia* Nanotrap® Antigen Test**

### ❑ Primary insurance

Required items include:

**1) Pre-payment information (complete above)**
**2) Front and back copies of insurance card(s)**
**3) Valid photo ID**

A reimbursement claim will be submitted to your insurance provider. Reimbursement depends on your individual insurance plan. Any reimbursement will be directly mailed to you **from your insurance provider.** Following reimbursement, we may contact you for a copy of your Explanation of Benefits (EOB).

### ❑ Medicare (primary insurance)

Required items include:

**1) Front and back copies of Medicare card**
**2) Valid photo ID**
**3) Completed Advance Beneficiary Notice Form (ABN)**

A reimbursement claim will be submitted to Medicare on patient's behalf. Any reimbursement deemed payable by Medicare will be mailed directly to Galaxy for reimbursement.

**If Medicare claim is denied, the patient is responsible for paying the full amount for the test(s).**

## Patient Insurance Information (For privately insured/Medicare patients only)

| | | |
|---|---|---|
| Primary Insurance Policy Provider Name | | Policy Number |
| Address of Primary Insurance Company (as indicated on Insurance card) | | |
| Group Number | Policy Holder's Name | Policy Holder DOB (mm/dd/yyyy) |
| Policy Holder Address | | |
| Policy Holder Daytime Telephone Number | Patient's Relationship to Policy Holder<br>☐ Self ☐ Spouse ☐ Child ☐ Other | Patient's Gender<br>☐ **Male** ☐ **Female** ❑ **Non-binary** |
| Secondary Insurance Policy Provider Name (If applicable) | | Secondary Policy Number |
| Address of Secondary Insurance Company (As indicated on Insurance card) | | |
| Secondary Group Number | Secondary Policy Holder's Name | Secondary Policy Holder DOB (mm/dd/yyyy) |
| Secondary Policy Holder Address | | |
| Secondary Policy Holder Daytime Telephone Number | Patient's Relationship to Secondary Policy Holder<br>☐ Self ☐ Spouse ☐ Child ☐ Other | |