



Patient Identification Label	
Name:	_____
MRN:	_____
DOB:	_____
Date of Service:	_____

MICROARRAY BILLING WAIVER

Chromosomal Microarray (CMA) Billing Policy

If insurance details are provided, University of Colorado Medicine will bill a patient's health insurance provider. However, if a claim is denied, the patient may be responsible for the entirety of the bill. Signing this waiver **prior to testing** guarantees a 40% discount off the list price of the test in the event that insurance denies the claim.

Please note the discounted price cannot be honored for any patient responsibility due after insurance billing.

Test Requested (Select One)	CPT Code	Description
	81229	Chromosomal microarray (for patients)
	81229-52	Targeted chromosomal microarray (for family members)

Please initial one of the following billing options:

I would like my insurance to be billed for the testing above. I agree to pay the discounted charges for this service in the event the claim is denied.

I am electing NOT to have these charges billed to my insurance company. I understand no claim to my insurance will be generated by CU Medicine for these services. I will remit payment at the 40% discounted price.

Patient (Print) _____

Date of Birth _____

Patient or Guardian Signature _____

Date _____

Relationship to Patient _____