Patient Identification Label
Name:_______________________
MRN: _______________
DOB: _______________
Date of Service: _________________

BILLING WAIVER

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 with an X)	CPT Code (add codes below as needed)	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**