Ambry Genetics®

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INSURANCE ORDERING CHECKLIST

- ☐ Copy of patient insurance card
- ☐ ICD-10 code(s)

Preverification of Benefits Form (Blue Sections Required)

Note: This is not a Test Requisition Form. To order a test, please complete a Test Requisition Form.

PATIENT INFORMATION

Last Name	First Name	Middle Initial	DOB (MM/DD/YY)	Date of Death (if applicable)

Street Address	City	State/Country	Zip

ORDERING PHYSICIAN AND/OR OTHER LICENSED MEDICAL PROFESSIONAL

Name (Last, First, Degree) (Clinician Code)	Phone	Fax	Email	NPI#

SENDING FACILITY

Facility Name (Facility Code)	Address	City	State/Country	Zip	Phone

FORM COMPLETED BY

☐ Primary Contact	Medical Professional Name (Clinician Code)	Phone	E-mail or Fax

INSURANCE BILLING (If supplying a copy of both sides of insurance card, ignore this section if relation to patient is Self)

Patient Relation to Policy Holder? ☐ Self ☐ Spouse ☐ Child	Name and DOB of Policy Holder (if not Self)

Insurance Company	Policy #	HMO Authorization #

TEST CODE AND TEST NAME (If requesting reflex, please indicate that in the notes section below)

Test Code	Test Name
Test Code	Test Name

NOTES

*This preverification of benefits form is not intended and will not be used to obtain an authorization from the insurance company. Authorization for testing will be performed upon sample receipt.

Return this completed preverification of benefits request form by:

- Fax: +1 949-900-5501
- Secure email: Preverification@ambrygen.com
- Secure upload through ambrygen.com (select *Destination: Preverification*) portal.ambrygen.com/secure-upload/