Ambry Genetics®

INSURANCE ORDERING CHECKLIST
☐ Copy of patient insurance card
☐ ICD-10 code(s)
☐ Medical Records

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

ICD-10 CODE(S)

NOTES

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/

7 Argonaut, Aliso Viejo, CA 92656 USA Toll Free +1.866.262.7943 Fax +1.949.900.5501 **ambrygen.com**

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