MYPG

PAYMENT & INSURANCE INFORMATION

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	GENDER

PATIENT PHONE # (PRIMARY)	EMAIL ADDRESS

PATIENT STATUS

HOSPITAL INPATIENT HOSPITAL OUTPATIENT NON-HOSPITAL PATIENT HOSPITAL / INSTITUTION NAME

PHONE	FAX

BILLING INFORMATION

BILL THE FOLLOWING: INSURANCE MEDICARE PART B HOSPITAL	SELF PAY: CHECK INCLUDED CREDIT CARD

PRIMARY INSURANCE PLEASE INCLUDE BOTH FRONT AND BACK COPIES OF INSURANCE CARD(S)

PRIMARY INSURANCE	POLICY NUMBER	GROUP NUMBER

INSURED NAME (WHO HOLDS THE POLICY)	INSURED DOB

PATIENT RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER:

INSURED STREET	INSURED CITY	STATE	ZIP

SECONDARY INSURANCE PLEASE INCLUDE BOTH FRONT AND BACK COPIES OF INSURANCE CARD(S)

SECONDARY INSURANCE	POLICY NUMBER	GROUP NUMBER

INSURED NAME (WHO HOLDS THE POLICY)	INSURED DOB

PATIENT RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER:

INSURED STREET	INSURED CITY	STATE	ZIP

SIGNATURE YOUR SIGNATURE AUTHORIZES PGDx TO RELEASE TEST RESULTS & MEDICAL RECORDS TO YOUR THIRD PARTY PAYER WHEN NECESSARY AS PART OF THE REIMBURSEMENT PROCESS.

	DATE