SANFORD
Laboratories

Commercial Insurance Patient Waiver of Liability (Non-Medicare)
Do not use this waiver for BCBS ND members or Medicare beneficiaries. Separate payer-specific waiver required.

Patient Name (Print) ________________________E# or Chart# ________________ Date of Service (required): _______

____Insured patients of commercial payers – includes BCBS Minnesota (check if applicable)

The laboratory testing ordered by your provider may not be considered medically necessary as defined by your health insurance plan **(Health Plan Name – required)** ______________________________. Your insurance plan may not pay for services it does not consider medically necessary or not meeting the qualifications under your policy.

____BCBS covered patients only (check if applicable) City and State where provider located (required): ______________

As a BCBS covered member, your insurer has medical policies to guide ordering providers in requesting medically necessary tests. BCBS medical policies may not support your ordering provider's reasons for ordering certain tests. Medical policies exist with BCBS for the tests indicated in the table below. Policy summaries can be found on the back of the form. Links to BCBS policies are also provided.

TESTS INDICATED BELOW MAY BE CONSIDERED "NON-COVERED" BY YOUR HEALTH PLAN POLICY, PLEASE CHECK YOUR POLICY FOR COVERAGE					
TESTING DESCRIPTION	SELECT TEST (X) REQUIRED	ORDER CODE	CPT CODES INITIAL TESTING (ALWAYS BILLED)	CPT CODES (BILLED IN ADDITION)	ESTIMATED CHARGE TO PATIENT INSURANCE
Chromosome Microarray, Congenital		LBOR0208	81229	N/A	$3,437
Chromosome Analysis, Congenital Disorders		LBOR0216	88230 AND 88291	88261 or 88262 or 88263	$439 - $1,222
Chromosome Microarray (CMA) Familial Testing, FISH		LBOR0217	88271x2, 88230 AND 88291	88272 or 88273 or 88274 or 88275 and where applicable 88271x1 up to x14	$565 - $1,599
Williams Syndrome, 7q11.23 Deletion, FISH		LBOR0219	88271x2, 88230 AND 88291	88272 or 88273 or 88274 or 88275 and where applicable 88271x1 up to x14	$565 - $1,599
Sex-Determining Region Y, Yp11.3 Deletion, FISH and Chromosome Analysis, Congenital		LBOR0220	88271x2, 88230 AND 88291	88272 or 88273 or 88274 or 88275 and one of 88261 or 88262 or 88263 and where applicable 88271x1 up to x14	$565 - $2,382
Known 45,X, Mosaicism Reflex Analysis, FISH		LBOR0221	88271x2, 88230 AND 88291	88272 or 88273 or 88274 or 88275 and where applicable 88271x1 up to x14	$565 - $1,599
22q11.2 Deletion/Duplication, FISH		LBOR0190	88271x2, 88230 AND 88291	88272 or 88273 or 88274 or 88275 and where applicable 88271x1 up to x14	$565 - $1,599
Aneuploidy Detection FISH (13, 18, 21, X, Y)		LBOR0218	88271x5, 88230 AND 88291	88272 or 88273 or 88274 or 88275 and where applicable 88271x1 up to x11	$754 - $1,599
Chromosome Microarray with 5-Cell Chromosome Analysis Reflex, Congenital		LBOR0239	81229, 88230 AND 88291	88261 or 88262 or 88263	$3,876 - $4,659

Patient Agreement: *(Must be understood & signed by all patients acknowledging financial responsibility regardless of insurer)*

I understand my health insurance may have medical policies regarding testing that has been ordered by my provider. I understand Sanford Laboratories will file a claim on my behalf as long as the billing information provided is valid and complete. I have elected to receive the services ordered and agree to pay for services if my insurance plan deems the services non-covered*

Patient or Responsible Party Signature (required): ___________________________________ Date (required): ________

Medical Provider or Delegate Signature (required): ___________________________________Date (required): ________

☐ **I choose to decline testing indicated member signature (required): ___________________Date (required): _______**

Phlebotomist or other medical provider signature indicates a meeting with the patient and an explanation regarding non-coverage was discussed and understood. **While an explanation of benefits may indicate otherwise, a valid, signed waiver constitutes financial liability on behalf of the policy holder.**