SANFORD
Laboratories

olemke
2025-03-19 04:33:43

8.5x11 20lb white, ink: color, pages front side only

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 MRN#** _____ **Date of Service (Print)** _____

____ **Insured patient of commercial payer – 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 meet benefit determinations defined under your policy.

____ **BCBS or Wellmark patients only (check if applicable): City, State where provider located (required):** _____

As a BCBS or Wellmark covered member, your insurer has medical policies to guide ordering providers in requesting medically necessary tests. BCBS or Wellmark medical policies may not support your ordering provider's reasons for ordering certain tests. Medical policies exist with BCBS or Wellmark for the tests indicated in the table below. Contact your insurance company to determine if the tests below require prior authorization or access their website using the links provided below.

TESTS INDICATED BELOW MAY BE CONSIDERED "NON-COVERED" BY YOUR HEALTH PLAN POLICY, PLEASE CHECK YOUR POLICY FOR COVERAGE					
TESTING DESCRIPTION	**SELECT TEST (REQUIRED)**	**ORDER CODE**	**CPT CODES - INITIAL TESTING (ALWAYS BILLED)**	**CPT CODES (BILLED IN ADDITION)**	**ESTIMATED CHARGE TO PATIENT INSURANCE**
Chromosome Analysis, Congenital		LBOR0216	88230	88261 or 88262 or 88263	$370-$1176

Patient Agreement: *(Must be understood and 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 if 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 as non-covered.

Patient or Responsible Party Signature (required): _____ **Date** _____ **Time** _____

Phlebotomist or Medical Provider Signature (required): _____ **Date** _____ **Time** _____

☐ **I choose to decline testing indicated (member signature and date)** _____ **Date** _____ **Time** _____

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.**

Wellmark's **Molecular Testing Vendor Policies** are administered by eviCore Healthcare by Evernorth Health Services. ***Many genetic or molecular tests require pre-approval or prior authorization prior to testing.***

BCBS Wellmark medical policies: https://authorization.wellmark.com/AuthTable/

BCBS Minnesota covered members can verify coverage by referring to your benefit booklet, Evidence of Coverage or Summary Plan description, by logging in to the member website or by calling the customer service number on the back of your member ID card. You will be required to provide your member ID group number and procedure code (CPT code) to verify coverage.

BCBS Minnesota medical policies: https://www.bluecrossmn.com/providers/medical-management/prior-authorization-lookup-tool