DOMINION DIAGNOSTICS

PATIENT INFORMATION UPDATE

PLEASE FILL OUT AND SUBMIT THIS FORM TO DOMINION DIAGNOSTICS IN ORDER TO:

1. Update patient information on file (e.g., address, phone)
2. Apply for a reduced rate for diagnostic services performed
3. Update insurance information on file

1 PATIENT INFORMATION UPDATE

ACCOUNT NUMBER _____

PATIENT NAME **(REQUIRED)** _____

DATE OF BIRTH (MM/DD/YY) _____

☐ **USE PATIENT ADDRESS ON FILE** (Check box to confirm the statement mailing address OR Update patient address below)

UPDATED PATIENT ADDRESS _____

CITY, STATE _____

ZIP _____

PATIENT PHONE **(REQUIRED)** ( ) -

2 REDUCED RATE REQUEST

HOUSEHOLD INCOME INFORMATION

CURRENT GROSS OR ADJUSTED GROSS ANNUAL INCOME (SELF) $ _____

CURRENT GROSS OR ADJUSTED GROSS ANNUAL INCOME (SPOUSE/PARTNER) $ _____

COMBINED TOTAL GROSS OR ADJUSTED GROSS ANNUAL INCOME (FAMILY) $ _____

TOTAL PERSONS IN HOUSE-HOLD (INCLUDING SELF) _____

PATIENT ACKNOWLEDGMENT & SIGNATURE

I hereby acknowledge the above information is true and accurate. I authorize Dominion Diagnostics to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation for the above request (e.g., W-2, paystub). I understand that if I do not qualify for a reduced rate, I will be notified by Dominion Diagnostics and responsible for my full bill. I hereby acknowledge that I am neither related to, nor employed by, the provider who ordered the testing.

SIGN HERE _____

Patient Signature (**Required for Request**)

_____

Date

DOMINION DIAGNOSTICS INTERNAL USE ONLY

STATEMENT: _____

REVIEWER: _____

☐ APPROVED FOR REDUCED RATE

☐ DENIED, Reason: _____

3 INSURANCE COVERAGE UPDATE

CURRENT INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE CARRIER _____

CLAIMS ADDRESS _____

CITY, STATE _____ ZIP _____

INSURANCE PHONE ( ) -

NAME OF INSURED PARTY _____

RELATION TO PATIENT _____

POLICY ID* _____

SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE CARRIER _____

CLAIMS ADDRESS _____

CITY, STATE _____ ZIP _____

INSURANCE PHONE _____

NAME OF INSURED PARTY _____

RELATION TO PATIENT _____

POLICY ID* _____

WORKERS' COMPENSATION ONLY (REQUIRED INFO)

DATE OF INJURY (DD/MM/YY) _____

CLAIM NUMBER _____

ADJUSTER NAME _____

ADJUSTER PHONE ( ) -

* Please visit **www.dominiondiagnostics.com/patient-information** for a list of Policy ID examples by Insurance Carrier

SUBMIT FORM: HIPAA Fax **(401) 667-0331** • Mail **Dominion Diagnostics Billing, PO BOX 638889, Cincinnati, OH 45263-8889**

INQUIRIES: Phone **1-800-511-8427, Option 4** • E-mail **patientinfo@dominiondiagnostics.com**