Patient Billing Policy

Genelex, 3101 Western Ave., Suite 100, Seattle, WA 98121 · Phone 877.431.4362 · Fax 206.219.4000 · CAP# 4344001· CLIA# 50D0980559 · NPI# 1770932501

Understanding what is covered by your insurance and what fees you'll need to pay, if any, can be difficult. This guide explains how Genelex bills your insurance provider and what balance, if any, you may be expected to pay.

Genelex is committed to making the benefits of pharmacogenetic testing accessible and affordable. If you don't have health insurance, are on a high-deductible plan, or your final patient responsibility poses a financial hardship for you, advance payment by credit card may be your best option. Please call us about our reduced pre-pay prices, payment plans and Financial Assistance Program.

Questions? Contact our Billing Department at 800-523-3080 or Billing@Genelex.com

What to expect:

1. Genelex will bill your insurance provider directly and send you a courtesy copy of the services submitted. You do not need to reply to the notice. You do not have to submit a claim. However, you should check with your benefits administrator to check if you are required to get pre-authorization for any coverage provided.
2. Your insurance provider will send you an Explanation of Benefits statement (EOB). It is not a bill. It is a report showing you how much your insurance company has paid Genelex for the services ordered and if any portion of the fees weren't covered by your plan. It will look something like this:

3. If any large patient balance or out-of-network deductible remains, Genelex will attempt to reduce any out-of-pocket cost to you by sending an appeal to your insurance provider. Some plans may require your permission to allow us to appeal on your behalf. Please sign and return any forms you receive from your insurance provider regarding this permission.
4. When we have exhausted all appeals, Genelex will send you an invoice showing the remaining balance and your amount due. Please note that the appeal process can sometimes take as long as four (4) months.
5. If you receive a check from your insurance company for the submitted Genelex's services, please endorse the check and mail to Genelex Labs LLC, 3101 Western Ave., Suite 100, Seattle, WA 98121
6. When testing is covered by your health plan: Genelex will always accept the plan's allowed amount. You will still be responsible for deductible or coinsurance amounts determined by your plan.
7. When testing is not covered by your health plan: Genelex will honor the patient billed cash pay amount as payment in full.

Coverage & Payment Options:

1. Medicare coverage is very limited and you will be asked to sign an Advanced Beneficiary Notice (ABN) form prior to testing if a test is not covered. An ABN form says you are accepting the full payment obligation for the testing. If you have a secondary payer or supplemental plan to Medicare, Genelex will bill that plan before billing you.
2. Commercial insurance and Medicare Advantage coverage varies by plan and provider. ***Turn over***

3. High-deductible plan participants not expecting to reach their annual deductible are encouraged to call us for our reduced patient pre-pay cash rate or payment plan options.
4. If your annual household income is below 400% of the national poverty guidelines, you may qualify for our Financial Assistance Program, which offers testing at reduced or no cost. Find out about current national poverty guidelines here: http://obamacarefacts.com/federal-poverty-level/
5. Our payment plan is available to anyone with a patient responsibility balance exceeding $100.00

Frequently Asked Questions:

1. What is a preauthorization?

   Some insurance plans require that a patient receive preauthorization from the insurance company prior to receiving certain medical services to make sure the company will cover expenses associated with those services.

2. What is an Explanation of Benefits or EOB?

   An EOB is a document that your insurance carrier sends to you where the insurance company explains the services they will cover for a patient's healthcare services. EOBs may also explain what is wrong with a claim if it's denied. An EOB is not an actual bill for you to pay. It is simply a notification for you, to show how your insurance processed the claim for your Genelex service and typically requires no action from you.

3. What is a copay?

   The amount that must be paid to a provider before they receive any treatment or services. Co-pays are separate from a deductible, and will vary depending on a person's insurance plan.

4. What is coinsurance?

   Coinsurance refers to your share of the costs of a covered health care service, as a percent and will be specific to your insurance plan. For example, if your insurance plan states that you have 20% coinsurance and you receive a bill for $1,000, you would pay $200 and your insurance would cover the rest. This assumes that you have already paid your annual deductible.

5. What is a deductible?

   The amount a patient must pay out-of-pocket before your insurer will start covering expenses. This dollar amount varies by insurance plan.

   Note: You may see a combination of deductible, copay, or coinsurance applied to your EOB.

6. What is an allowed amount?

   The sum an insurance company will reimburse to cover a healthcare service or procedure. The patient typically pays the remaining balance if there is any amount left over after the allowed amount has been paid. Genelex however does not "balance bill" and will accept the allowed amount. This amount should not to be confused with co-pay or deductibles owed by a patient.

7. What is the billed cash pay amount?

   The reduced cash pay amount that you will be invoiced if your insurance does not cover testing.

8. What is a diagnosis code?

   ICD-10 codes are codes that represent diagnoses of patients' medical conditions as determined by physicians. Medical billing specialists input those codes into a claim for processing.

9. What is a CPT code?

   A CPT (Current Procedural Terminology) code is a medical code used to report a medical/diagnostic services to physicians and insurance companies.

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A. Notifier: **Physician:**

Address:

Genelex Labs LLC
3101 Western Ave, Suite 100
Seattle, WA 98121

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for lab tests checked in box **(D)** below, you may have to pay. We expect Medicare may not pay for the lab tests checked in box **(D)** below.

(D) **Lab Tests & Estimated Cost**	☐ Polypharmacy Panel $449	☐ Polypharmacy Comprehensive $599	☐ Polypharmacy Basic Panel $375	☐ Cardiology Panel $563
	☐ Thrombosis Panel $300	☐ Warfarin Panel (Coumadin) $300	☐ Psychotropic Panel $449	☐ Psychotropic Plus $638
	☐ Analgesic Panel $488	☐ ADHD Panel $300	☐ ADRA2A $149	☐ COMT $149
	☐ CYP1A2 $149	☐ CYP2B6 $149	☐ CYP2C9 $188	☐ CYP2C19 $188
	☐ CYP2D6 $225	☐ CYP3A4 $149	☐ CYP3A5 $149	☐ DPYD (DPD) $149
	☐ GRIK4 $149	☐ HTR2A $149	☐ HTR2C $149	☐ NAT2 $149
	☐ OPRM1 $149	☐ SLC6A4 (5-HTT) $149	☐ SLCO1B1 $149	☐ VKORC1 $149
	☐ F2 (Factor II) $149	☐ F5 (Factor V) Leiden $149	☐ MTHFR $149	☐ Apo-E $149
	☐ HLA-B*15:02 $225	☐ HLA-B*58:01 $225	☐ HLA-B*57:01 $225	☐ HLA-A*31:01 $225
(E) **Reason Medicare May Not Pay**	1.) Not indicated for diagnosis and/or treatment in this case **OR** 2.) Experimental and investigational or considered "research only"			
(F)				

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐**OPTION 1.** I want the **lab tests** checked above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐**OPTION 2.** I want the **lab tests** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐**OPTION 3.** I don't want the **lab tests** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information: Contact Genelex Corporation for ABN copies and billing/claims concerns.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**