Patient Billing Policy:

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

Genotox is committed to making the benefits of toxicology and PGX 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, please ask us about our payment plans and Financial Assistance Program, which includes reduced fee options for those who qualify. It is our goal that cost should not be the obstacle to you receiving the benefit of personalized prescribing.

Please call Genotox directly at 844-797-9647 with any questions or concerns you have about your statement. Your doctor will NOT be able to help you with billing questions because they are not part of Genotox.

What to expect:

1. Genotox 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. Please keep in mind, certain insurance carriers may require Pre-Authorization.

2. Your insurance provider will send you an Explanation of Benefits statement. It is not a bill. It is a report showing you how much your insurance company has paid Genotox for the services ordered and if any portion of the fees weren't covered by your plan.

3. If any large patient balance or out-of-network deductible remains, Genotox 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.

4. When we have exhausted all appeals, Genotox 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 Genotox services, please endorse the check and forward it to Genotox Laboratories, 2170 Woodward St Suite 100, Austin, TX 78744

6. *When testing is covered by your health plan:* Genotox will always accept the plan's allowed amount. You will still be responsible for any deductible or coinsurance amounts determined by your plan.

7. *In the event testing is not covered by the patience health plan, Genotox Labs will make payment arrangements directly with the patient.*

Coverage & Payment Options:

- Commercial insurance and Medicare Advantage coverage varies by plan and provider.
- Health Savings Account (HSA/HRA) funds cannot be refunded unless a patient qualifies for our Financial Assistance Program.
- If your annual household income is below 600% of the national poverty guidelines, you may qualify for our Financial Assistance Program which offers testing at reduced or no cost.
- Our payment plan is available to anyone with a patient responsibility balance exceeding $200.00.

Questions? Contact our Billing Department at 1-844-797-9647

Service for Indigent Patients

Genotox Laboratories provides Urine Drug Testing and Pharmacogenomic testing services to Physicians to enable them to provide better care for their patients. Genotox Laboratories is committed to providing the highest level of service for all of our customers and the patients they recommend for our laboratory testing services.

Genotox is often asked if we can provide our services for patients who are unable to pay or have no insurance. We believe it is part of providing a quality healthcare service that it be available to all those who need the services we offer. If you have a patient/are a patient who needs the Genotox services and are unable to cover the cost of the testing please complete this form.

Name: _____

Address: _____

_____

_____

Phone: _____

Patient Signature: _____ Date: _____

Print Name: _____

Signature and Certification - I certify that at the present time I am unable to pay for or do not have insurance coverage that will pay for the cost of the testing my doctor has ordered.

M.D. Signature: _____ Date: _____

Print Name: _____

I certify that the patient above does not have the financial means to pay for the testing I have ordered and need to properly manage their clinical situation.

Date received by accounting: _____ Date Sent to Billing Company: _____