DiagnosTechs™
CLINICAL & RESEARCH LABORATORY

19110 66th Avenue South, Building G
Kent, Washington 98032
800.878.3787 | FAX: 425.264.0612
www.diagnostechs.com

BLANKET BILLING AUTHORIZATION FORM

Provider Name: _____ **NPI #:** _____

Clinic Name: _____ **DTI Account Number:** _____

Phone Number: _____ **FAX Number:** _____

PLEASE NOTE: ALL ACCOUNTS ARE REQUIRED TO PROVIDE A CREDIT CARD NUMBER AND TO PREPAY FOR 90 DAYS – NO EXCEPTIONS

Type of Credit Card: Visa ☐ Master Card ☐ AMEX ☐

Billing Preference: Monthly ☐ Per Test ☐

Billing Address: _____ **Unit #** _____

City: _____ **State/Province:** _____ **Zip/Postal Code:** _____

Name on Card: _____ **Expiration Date:** _____ (MM/DD/YYYY)

Card Number: _____ **Security Code:** _____ (3 digit number on back of card/or 4 digits on front of AMEX)

Provider Tax ID Number: _____

Signature: _____

BILLING OPTIONS

ACTION REQUIRED: Please check ***one*** option below and fax this form to 425-264-0612

☐ **Provider Billing**

The credit card on file will be charged according to the billing preferences. Printed statements are sent out once a month and accessible online.

After 90 days of active billing, provider may opt for the net 30-day billing account.

☐ **Patient Billing/Insurance Billing**

Patients are required to send payment or billable insurance information with all tests submitted. Please provide the cost of the test(s) on the requisition form for a patient submitting payment.

Patients may pay using check, money order, or credit card. Test results will not be released without payment or billable insurance information. For insurance information, please call 1-800-878-3787 and ask to speak with an Insurance Billing specialist.

☐ **Not Defined Billing**

A "Not Defined" account means the account can be billed by either of the two options above. Please indicate the billing option on each requisition form. If we are to bill provider, provider ***must*** sign the form. All of the above billing requirements apply to the option chosen for each accession.

Please ***do not*** sign the form if patient should pay; this may result in delay for releasing test results.

I, _____ , certify that I am financially responsible and will be held accountable for the account listed above. I understand the billing option chosen above with the corresponding terms and conditions will be applied to all tests submitted.

Authorized Signature: _____ **Date:** _____

Printed Name: _____