LabCorp **Statement of Financial Responsibility**

Section A: Member/Patient Information

Member/patient name: _____ / Date of birth: _____

Address: _____

City: _____ / ST: _____ / ZIP: _____

Specimen #: _____ / Client account #: _____ / Client phone #: _____

Subscriber #: _____

Section B: Requested procedure or service information

Based on information given to us by your insurance plan, your plan is **not expected to pay 100%** for the laboratory test(s) ordered by your physician/healthcare provider (marked below).

Test/CPT Description	Reason for Patient Out of Pocket	Estimated Cost*

Total Estimated Patient Responsibility*: _____

*This is only an estimate. Actual amount owed may be adjusted based on final coverage amount.

Next Steps:

- Read this notice and decide if you agree to be financially responsible for the estimated patient responsibility costs listed above.
- Choose an option below about whether to receive the items listed in Section B above.
- Sign below and return this form to us within 5 calendar days via email, fax, or mail to the addresses listed below. We will not proceed until we receive this signed consent form with an option checked.

Section C: Options — Check only one box. We cannot choose a box for you.

☐ Option 1 — **I want** the laboratory test(s) marked above to be performed. I understand that my insurance plan is not expected to pay for these test(s) at 100% and I agree to be personally and fully responsible for payment.

  ☐ I would like to set up a payment plan for $_____a month.**

☐ Option 2 — **I want** the services listed above, but **do not** bill my insurance. I understand I cannot appeal the coverage of these services with my insurance plan if they are not billed. Discounts may apply to the services listed above. Payment in full is required in order to proceed with the testing services.

☐ Option 3 — **I do not want** the laboratory test(s) marked above to be performed. I understand with this choice I am not responsible for payment. No test will be performed and my plan will not be billed.

Patient can contact the Billing department at 888-210-9264 to discuss payment options. For non-billing questions, call 855-488-8750.

**Your first invoice will include the full balance due. If your payment plan is approved, you will receive another invoice that reflects your requested payment amount.

Signature: _____ / Date: _____

Please print name: _____

LabCorp

www.LabCorp.com

Email this form to: / **Fax this form to:**

Mail this form to: LabCorp Prior Authorization
PO Box 2230 / Millstream Mailstop 285 / Burlington NC 27216-2230