PG$_{XL}$ Laboratories Charge Reduction

201 E. Jefferson St., Suite 309, Louisville KY 40202
Phone: 502-569-1584 Fax: 502-569-1586 CLIA# 18D0983143

All information provided herein will be held in confidence by PGXL Laboratories personnel and will be shared strictly on a need-to-know basis.

Patient Information

Name (Last, First, MI)		Phone	
Address	City	State	Zip

Health Insurance		Place of Employment	
Insurance Company		Patient's Employer	
Member/Insured ID #	Plan #	Responsible Party's Employer	

Please attach a photocopy of patient's insurance card.

Family Income and Size

Family Income $	Number of Dependents

Please attach a copy of your most recent IRS Form 1040 (pages 1 and 2) or 1040EZ (page 1). You do not need to include copies of schedules, but must include the signature page.

I, ______________________________, certify that the above information is true, complete and accurate and that this application is made to allow PGXL Laboratories to determine my eligibility for reduced out of pocket health care costs. I further certify that I am not covered by Medicare, Medicaid, or any other government health insurance program. I understand that if any of the information that I have provided is untrue, PGXL Laboratories will promptly reevaluate my financial status and may take such action as is necessary, including all remedies available under the law, to collect on my account.

Signature of patient or parent or legal guardian if patient is a minor:

Signature: Date:

(For PGXL use only)

PGXL Accession Number:		
Patient Balance Due Before Adjustment:	$	(balance due after all insurance payments)
Maximum Patient Responsibility:	$	(based on adjustment table)
Personalized Patient Credit:	$	(balance due) – (patient responsibility)

Authorized Signature: Date: