This Is NOT a Bill

The Explanation of Benefits is from your insurance company. It not necessarily represent the amount you will owe.

	OMPANY	This docu	ment shows how benefit during the same of	Statement Statement were applied to claim were applied to claim a member resource.
Print Date:			т	HIS IS NOT A BILL
Plan Subscriber: Subscriber ID:		Claims Summary		
Group Name:		We processed 1 claim on you		
Group ID:		Contact the provider(s) to if not already paid.	arrange payment,	Total Member Responsibility to
Save	e a tree. Go paperless at	if not already paid.		Provider(s)
		Total	Paid:	81.0
ms Detail - How your benefits were used to calc	ulate these claims			
ient: ient Year of Birth: ient Account with Provider:		à		
im ID: Amount of Service Charged by ce Description Provider	Amount Not Regence Covered Member Rate Co-pa	Pemaining Member Amount Coinsurance	Regence Paid	To Provider(s
im ID: Amount of Service Charged by ice Description Provider 20/16 Laboratory -	Covered Member Rate Co-pa	y Deductible Amount Coinsurance	e Regence Paid	Member's Responsibility To Provider(s
Im ID: Amount of Service Charged by bescription Phonder 20/16 Laboratory - PXN Pricing is based on	Covered Member Rate Co-pa	y Deductible Amount Coinsurance	e Regence Paid	To Provider(s
im ID: Amount of Service Charged by ca Description Pholder 20/16 Laboratory - PXN Pricing is based on	Cound Member Reek Department	2 Dekatele Anovi Concurro	e Regence Paid	To Provider(s
In ID: Anore <u>estimation</u> Coppeting Poster 2016 Laconton PSN Process 2017 Totals for this claim:	Coverd Memory Rev Council Series	2 Devicebe Amount Consumo conder:	e Regence Paid	To Provider(s
In ID: Anore <u>estimation</u> Coppeting Poster 2016 Laconton PSN Process 2017 Totals for this claim:	Cound Membrine Department	2 Devictor Anour Consumo oxder	e Regence Paid	To Provider(s

This Is a Bill

The bill is from GeneSight. This is the amount you will owe.

PO Box 64567 Cincinnati, OH				BILLING QUESTION F/	NS: 888.496 AX: 888.605
PATIENT NAME: JOHN Q. PATIENT	PATIENT ACCT NO.: 0000000	REFERRING PHYSICIAN: DR. SALLY DOCTOR	CLIENTNAME: CLINIC ABC	STATEMENT DATE: 07/17/2017	PAGI 1
Date Units	CPT Code	Description	Charges	Payment or Adjustment	Total D
03/21/17	CYP2C19 GENE CO				
06/13/17	Insurance Provider				
06/13/17	CYP2D 6 GENE CO				
06/13/17	Insurance Provider				
06/13/17 06/13/17	CYP2C9 GENE CO				
06/13/17	Insurance Provider MTHER GENE				
06/13/17	Insurance Provider				
06/13/17	ZBZV6				
06/13/17	Insurance Provider				
06/30/17	PAYMENT Check#				
04/04/17	PATIENT PATIEN				
		Absolution			
Message:		I Amount Due :	ng balance due. Our	Billing Team is here	to
Thank you for yo serve you Monda	ur payment. Your stater ay through Friday from 8	nent reflects your remaini a.m. to 8 p.m. (ET) by ca		Billing Team is here Patient Stat	
Thank you for yo serve you Monda	ur payment. Your stater ay through Friday from 8	nent reflects your remaini a.m. to 8 p.m. (ET) by ca	alling 888.496.2391.		
Thank you for yo	ur payment. Your stater ay through Friday from 8	nent reflects your remaini a.m. to 8 p.m. (ET) by ca Patient	alling 888.496.2391.		
Thank you for yo serve you Monda	ur payment. Your stater ay through Friday from 8 ight*	nent reflects your remaini a.m. to 8 p.m. (ET) by ca Patient PAYM	Illing 888.496.2391.	Patient Stat	ement
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Thank you for yo serve you Monda GODOS PO Box 64567 Cincinnati, OH	ur payment. Your stater ay through Friday from 8 ight 4 45254-5674 3 QUESTIONS: 888.496.2391	nent reflects your remaini a.m. to 8 p.m. (ET) by ca Patient Paym • To pa • To pa • If you	No: 0000000 IENT OPTIONS y online, please visit G y by phone, please cal r statement is \$100 or: r statement is \$100 or:	Patient Stat	nts an
Thank you for yo serve you Monda GODOS PO Box 64567 Cincinnati, OH	ur payment. Your stater ay through Friday from 8 ight [*] 4 445564-5674	nent reflects your remaini a.m. to 8 p.m. (ET) by ce Patient PAYM • To pa • To pa • If you intere	Illing 888.496.2391. No: 0000000 IENT OPTIONS y online, please visit G y by phone, please cal r statement is \$100 or st-free payment plan b	Patient Stat ieneSight.com/paymen I 888.496.2391 more, you can set up a y calling 888.496.2391	ement nts
Thank you for yo serve you Monda GODOS PO Box 64567 Cincinnati, OH	ur payment. Your stater ay through Friday from 8 ight 4 45264-5674 3 QUESTIONS: 888.496.2381 FAX: 888.486.2381	nent reflects your remaini a.m. to 8 p.m. (ET) by ce Patient PAYM • To pa • To pa • If you intere • To pa • Wour Neur	Illing 888.496.2391. No: 0000000 IENT OPTIONS y opline, please visit G y by phone, please cal r statement is \$100 or st-free payment plan b y by check, please ma	Patient Stat	ement nts an Myriad
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GENESIGHT PROMISE

Insurance can be complicated, and we want you to feel comfortable knowing what you'll owe. We promise if your patient responsibility could be more than \$330, we'll call you before we process the test. If you have any questions regarding your insurance Explanation of Benefits or your bill, please contact:

888.496.2391 or visit us online at GeneSight.com/cost