Insurance Verification

Please email completed form to PatientNavigator@CarisLS.com or fax to 866-479-4925.

PATIENT INFORMATION

Last Name	First Name	MI

SSN	DOB	Gender ☐ Male ☐ Female

Address	Apt.

City	State	Zip

Phone	Work Phone or Email

INSURANCE INFORMATION (complete below or attach the front and back of PRIMARY and SECONDARY insurance cards)

Insurance Provider	Policy #	Group #	Insured Name	Insured DOB	Relationship to Patient	Prior Authorization #
Primary						
Secondary						

ORDERING PHYSICIAN AND FACILITY INFORMATION

Office/Institution Name

Ordering Physician

Physician Phone	Physician Email

I authorize Caris Life Sciences to use my information to review my insurance coverage and estimate potential financial responsibility for molecular testing. Actual coverage will be determined when the claim is officially submitted.

Patient Name (Print)	Signature	Date

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