MOLECULAR VISION

Pre-Verification/Pre-Authorization Information Form

Patient Information (please complete in full)

Patient's Last Name:

First Name:

MI:

Date of Birth:

Patient Address:

Contact Name:

Contact Phone:

Contact Email:

Insurance Information (please complete in full)

Insurance Company:

Insurance Claims Address:

Insurance Phone Number:

Policy ID #:

Group Name/Group #:

Subscriber Name:

Subscriber DOB:

Relationship to Patient:

Ordering/Referring Provider Information

Ordering Provider Name:

Ordering Provider Address:

Ordering Provider NPI:

Test Information (please request this information from your ordering provider)

Date of Request:

Test Name:

CPT Codes:

Diagnosis (ICD-10 Codes):

Please attach the following forms:

- ☐ Letter of Medical Necessity (required; to be completed by the ordering provider)
- ☐ Relevant Medical Records (required; to be provided by the ordering provider)
- ☐ Copy of front and back of insurance card (required)

Please email the completed form and attachments to benefits@nexushs.com or fax them to 323.978.5490. If you have any questions, please call our billing department at 310.872.1132 option 5.