Tulsa Medical Laboratory, LLC
2738 E. 51st Street, Suite 290
Tulsa, OK 74105-6271
Phone No.: (918) 712-5571

HEALTH INSURANCE INFORMATION

IF HEALTH INSURANCE PROCESSING IS NOT REFLECTED ON THIS BILLING AND YOU WOULD LIKE US TO FILE A CLAIM DIRECTLY FOR YOU PLEASE COMPLETE & RETURN THE ENCLOSED INSURANCE FORM WITHIN 30 DAYS OR YOU WILL REMAIN RESPONSIBLE FOR THIS BILL.

INSURED'S NAME (Last Name, First Name, Middle Initial) Insurance ID#

PATIENT'S NAME (Last Name, First Name, Middle Initial) Insurance ID#

PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

PATIENT'S RELATIONSHIP TO INSURED
☐ Self ☐ Spouse ☐ Child ☐ Other

TO INSURE PROPER CREDIT PLEASE ENTER ACCOUNT/INVOICE NUMBER IN THE SPACE PROVIDED BELOW.
Acct# _____

PATIENT STATUS
☐ Single ☐ Married ☐ Other
☐ Employed ☐ Full Time Student ☐ Part Time Student

PRIMARY INSURANCE NAME AND PHONE #

PRIMARY INSURANCE ADDRESS CITY STATE ZIP CODE

PRIMARY INSURED'S ID/SS# DATE OF BIRTH MM DD YY EMPLOYER GROUP #

SECONDARY INSURANCE NAME AND PHONE #

SECONDARY INSURANCE ADDRESS CITY STATE ZIP CODE

SECONDARY INSURED'S ID/SS# DATE OF BIRTH MM DD YY EMPLOYER GROUP #

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits whether to myself or to the party who accepts assignment.

SIGNED _____ DATE _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services.

SIGNED _____

PAYMENT INFORMATION

Provide credit card information to pay by credit card.

IF PAYING BY CREDIT CARD PLEASE FILL OUT INFORMATION

Credit card type: ☐ Visa ☐ Master card

TO INSURE PROPER CREDIT PLEASE ENTER ACCOUNT/INVOICE NUMBER IN THE SPACE PROVIDED BELOW.
Acct# _____

Credit card Number: _____

Expiration date: _____

This information is needed to avoid potential delays in processing your credit card, please provide your complete name, and billing address and phone number as on your credit card.

First Name: _____

Last Name: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone # _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE FOR ABOVE CREDIT CARD INFORMATION.

SIGNED _____ DATE: _____