i-Labs
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Medicare Intake Form

Patient Information

Patient Name	Date of Birth (MM/DD/YYYY)

Sex	Social Security Number
☐ Female ☐ Male ☐ Other/Unspecified	

Medicare Beneficiary ID (MBI)	Medicare Part B Effective Date

Is Medicare your primary insurance?	If no, please list your primary insurance
☐ Yes ☐ No	

Include a clear copy of the FRONT AND BACK of your Medicare card. Both sides are required.

Medicare Coverage

i-Labs is enrolled with Medicare to provide laboratory services under Original Medicare Part B. This Medicare submission process does not include Medicare Advantage (Part C) plans.

Ordering Provider Information

Ordering Provider Name	Clinic Name

Ordering Provider NPI	NPI is required for Medicare billing. Please contact your provider's office if you are unsure.

Assignment of Benefits & Billing Authorization

I authorize i-Labs to submit claims to Medicare for laboratory services provided to me and authorize payment of Medicare benefits directly to i-Labs when permitted.

I authorize i-Labs and its billing representatives to release information reasonably necessary to Medicare and other entities involved in payment or coordination of benefits for purposes of processing my claim.

Financial Responsibility

I understand that submission of a claim to Medicare does not guarantee coverage or payment. I understand that I may be financially responsible for applicable charges that Medicare does not cover, subject to Medicare requirements.

I understand that certain laboratory services may require an Advance Beneficiary Notice of Noncoverage (ABN). When applicable, the ABN will explain why Medicare may not pay, the estimated cost, and my options before the service is provided.

Patient Certification & Authorization

I certify that the information provided on this form is true and complete to the best of my knowledge. I authorize i-Labs to use and disclose information as necessary for treatment, payment, healthcare operations, Medicare billing, and other purposes permitted or required by law.

Patient/Authorized Representative Signature	Date

Printed Name	Relationship to Patient (if applicable)