# OUT-OF-POCKET DISPUTE FORM

**This form is to dispute any out-of-pocket (OOP) expenses billed to the patient on an official GeneDx-issued statement.**

Please complete the information below and return the signed form with any relevant documentation to: billing@genedx.com or call us at (888) 729-1206, dial option 2, repeat 2. We will process the dispute and notify you once it has been reviewed and adjudicated. Please allow up to 5 business days for processing.

**Do not pay any invoices you may receive until you receive notification from our Billing department.**

*Note: An incomplete request or failure to respond to GeneDx's contact attempts will result in delayed processing or a voided dispute request.*

## PATIENT INFORMATION

Patient Name: _____ _____ Patient D.O.B.: _____
First Last

Telephone Number: _____ Email Address: _____

## DISPUTE

1. Statement amount: $_____

   Amount in dispute: ☐ Full amount

   ☐ Partial amount: $_____

2. Reason for dispute (check all that apply):

   ☐ I was not notified that I would have an OOP.

   ☐ I was notified of my OOP amount, but it was too late to cancel my test.

   ☐ The amount charged on my statement is significantly higher than the amount that I was quoted prior to my test.

   GeneDx estimated my OOP to be: $_____

## ATTESTATION

I HEREBY ACKNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT IF MY DISPUTE IS NOT RESOLVED IN MY FAVOR, I WILL BE NOTIFIED AND GENEDX WILL BILL ME. I HEREBY ACKNOWLEDGE THAT I AM NEITHER RELATED TO, NOR EMPLOYED BY, THE PHYSICIAN WHO ORDERED THE TESTING. I UNDERSTAND AND AGREE THAT GENEDX RESERVES THE RIGHT AT ANY TIME AND WITHOUT NOTICE TO MODIFY THE APPLICATION FORM OR TO MODIFY OR TERMINATE THIS PROGRAM. I FURTHER CERTIFY AND AGREE THAT GENEDX HAS CONDUCTED A CONCERTED EFFORT TO COLLECT ON MY FULL OUT-OF-POCKET RESPONSIBILITY, AND THAT I HAVE INDEPENDENTLY ELECTED TO CONTEST THESE CHARGES.

Patient/Responsible Party Signature: _____ Date: _____

Print Name: _____