



Washington State Department of Health
Newborn Screening Laboratory
Payment Form for Infant's First Newborn Screen (NBS)

Mail form with first NBS specimen to State Lab. For use with home collections only.



PATIENT INFORMATION			
Infant's Last Name:	First Name:	Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Place of Birth: <input type="checkbox"/> Home <input type="checkbox"/> Birth Center	Midwife Name:	NPI Number:	
Mother's Last Name:	First Name:	NBS Barcode No. (bottom right corner):	

OPTION 1: SELF-PAY		
For self-pay clients, payment <i>must</i> be submitted with first NBS specimen. Enclose check or money order payable to Washington State Department of Health for \$119.30		
Check No.:	Amount Enclosed:	<i>Please write the NBS barcode number on your check or money order.</i>

OPTION 2: BILL MY HEALTH INSURANCE					
Primary Insurance:			Secondary Insurance (if applicable):		
ID No.:	Group No.:		ID No.:	Group No.:	
Subscriber's Name:			Subscriber's Name:		
Date of Birth:	Phone No.:		Date of Birth:	Phone No.:	
Subscriber Address:			Subscriber Address:		
City:	State:	Zip Code:	City:	State:	Zip Code:
Relationship to patient: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other _____			Relationship to patient: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other _____		
I authorize the Washington State Department of Health to release information required to process my health insurance claims. I understand that I am financially responsible for any balance. I authorize my insurance benefits be paid directly to the Washington State Department of Health.					
X _____			_____		
Patient/Guardian Signature (Required)			Date		



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Subscriber's Name:			Subscriber's Name:		
Date of Birth:	Phone No.:		Date of Birth:	Phone No.:	
Subscriber Address:			Subscriber Address:		
City:	State:	Zip Code:	City:	State:	Zip Code:
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