



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 \$84.50.		
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.					
_____			_____		
Patient/Guardian Signature			Date		



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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:
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