Insurance Benefit Investigation Form

Helix

Please complete your information in the designated fields below, download the form once finished, and submit it to Helix by email at reimbursement@helix.com or by fax at 858-777-3670.

Patient/Subscriber Information

First Name		Last Name	
Date of Birth		☐ Male	☐ Female
Primary Insurance Name			
Plan Type			
Primary Policy Number			
Effective Date of Coverage			
Termination Date			
Secondary Insurance Name			
Plan Type			
Secondary Policy Number			
Termination Date			
Test Being Ordered			
Diagnosis Code*		Provider NPI*	
How would you like us to contact you (email or phone)			

**Optional for patients filling out this form*