Medicare Referring Physician Signature Authorization Form

I authorize Genova Diagnostics, Inc. to accept the signature shown below as my true signature on all claim submissions. This will remain in effect, unless revoked upon my written request.

Date: _____

Healthcare Practitioner Name: _____
(Please print/type full name here)

Healthcare Practitioner Type 1 NPI: _____ GDX ID #_____
(Please Confirm)

Signature of Practitioner: _____
(Please sign full, legible signature)