

**Billing Entity, Laboratory Services, and Fee Schedules**

**Purpose:** The purpose of this procedure is to outline the billing entity, types of laboratory services performed at Foundation Labs and associated fees.

**Billing Entity**

<b>Billing Entity</b>	Foundation Labs
<b>NPI</b>	1639642564
<b>Tax ID</b>	83-0653027
<b>Laboratory Address</b>	701 E. 28 <sup>th</sup> St., Suite 317 Long Beach, CA 90806
<b>Payment Address</b>	Mailstop: 96530421 PO BOX 660535 Dallas, TX 75266-0535

**Contact Information**

<b>Change Healthcare</b> (Billing Vendor as of 9/14/2020)	866-500-9722
<b>MCCB</b> (Billing Vendor prior to 9/11/2020)	800-719-0840
<b>Foundation Labs Customer Service</b>	562-490-9900

**Financial Responsibility for Families - Deposit**

<b>PPO, Medicaid, Private, Other</b>
\$500.00 due at the time of the appointment
<b>HMOs and Kaiser Insurance</b>
\$1000.00 due at the time of the appointment And \$1500.00 due within 4 months, per lab visit
<b>Cash Patient</b>
\$1000.00 due at the time of the appointment And \$1500.00 due within 4 months, per lab visit
<b>International Patients</b>
\$2500.00 due at the time of the appointment

**Laboratory Services and Fee Schedules**

Description	Procedure*	Units	Fee/Charge	Total Fee
Gammaglobulin (immunoglobulin); IgA, IgD, IgG, IgM, each	82784	1	\$34.40	\$34.40
Gammaglobulin (immunoglobulin); IgE	82785	1	\$34.40	\$34.40
Gammaglobulin (immunoglobulin); immunoglobulin subclasses (eg, IgG1, 2, 3, or 4), each	82787	4	\$168.00	\$672.00
Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified	83520	4	\$139.00	\$556.00
Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	85025	1	\$28.75	\$28.75
Allergen specific IgG quantitative or semiquantitative, each allergen	86001	11	\$23.45	\$257.95
Allergen specific IgE; quantitative or semiquantitative, crude allergen extract, each	86003	48	\$19.25	\$924.00
Allergen specific IgE; quantitative or semiquantitative, recombinant or purified component, each	86008	65	\$67.30	\$4374.50
Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker	88184	1	\$200.00	\$200.00
Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)	88185	2	\$200.00	\$400.00
<b>Family's maximum Out-of-Pocket Cost is not to exceed \$2500.00.</b>				

\* Services listed above are the recommended baseline laboratory tests and subject to change based on the treatment plan. Out-of-pocket costs will vary based on benefits and determined after the claim has been processed by the insurance carrier. Please confirm with the insurance plan if an authorization is required, please note, an authorization is not a guarantee of payment.

**END DOCUMENT**