Form is on second page. This form can be used for a patient to updated demographic and insurance information as part of the verification and billing processes.

**Patient Information Update Form**

To update your account information, please complete any field which has changed. If you have any questions about this form, please contact our **Billing Department at 844-508-9409**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Information** | | | |
| First Name |  | Address |  |
| Last Name |  | City |  |
| Date of Birth |  | State |  |
| Phone Number |  | Zip |  |
| Email |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Insurance** | | **Secondary Insurance** | |
| Insurance Carrier |  | Insurance Carrier |  |
| Subscriber ID |  | Subscriber ID |  |
| Group# |  | Group# |  |
| Employer |  | Employer |  |
| Insurance Claims Address |  | Insurance Claims Address |  |
| Insurance Phone Number |  | Insurance Phone Number |  |
| Subscriber |  | Subscriber |  |
| Subscriber DOB |  | Subscriber DOB |  |
| Relationship to Subscriber |  | Relationship to Subscriber |  |

|  |
| --- |
| **Comments** |
|  |

Please submit this form by one of the methods below.

|  |  |  |
| --- | --- | --- |
| **By Email:** | **By Fax:** | **By Mail:** |
| [billing@renalytixai.com](mailto:billing@renalytixai.com) | 801-210-6751 | Renalytix AI, Inc.  P.O. Box 848960  Boston, MA 02284-8960 |