PREVENTION GENETICS

DISEASE PREVENTION THROUGH GENETIC TESTING

Office use only

3800 S. Business Park Ave
Marshfield, WI 54449
Phone: 715-387-0484
Fax: 715-384-3661

Add-On Test Requisition

(revised 12/30/16)

- This form should be used to request additional testing on existing samples.
- Test information is available at www.preventiongenetics.com.
- Testing must be ordered by a qualified healthcare provider.

Requesting Provider	*Contact Information (phone or email)*	*Date of Request*	*Person Completing Form*

Patient Information

Patient's Last (Family) Name	*First Name*	*M.I.*	*Date of Birth:* *Month* *Day* *Year*

Patient ID Code	*PreventionGenetics ID#*

Our preferred method of report transmission is secure email (via ZixCorp). Please provide an email address when possible.
Please mark <u>all</u> that apply:

☐ ***Use same ordering provider/reporting contacts***

☐ ***New ordering provider(s)***
Please provide name, institution, address, and reporting information:

Secure Email (via ZixCorp):

☐ ***DO NOT use ZixCorp. Instead, send email via ShareFile.***

☐ ***DO NOT email results. Instead, send via fax (provide fax #):***

Additional Test Selection

*Please list below the tests that are to be added. The Test Numbers and Names, and turnaround time (TAT) can be obtained from our web site preventiongenetics.com. Please include any special test instructions in the comments section. The tests will be performed in the order listed unless otherwise specified. Unless specifically requested we will run Sanger panels sequentially. **We offer a STAT option for Sanger sequencing and gene-centric aCGH. The great majority of STAT tests are completed within 8 calendar days. If we are unable to complete STAT requests within 10 days, surcharge will be waived. <u>NextGen panels are not currently available to be ordered STAT.</u>*

Test Order	*Test Code*	*Test Name*
1		
2		
3		
4		

Special Instructions:

☐ ***Concurrent Testing***
(All tests ordered, including genes within panels, to be run simultaneously.)

☐ ***STAT Testing*****
(For STAT add 25% to price. Tests ordered will be run concurrently unless otherwise instructed.)

☐ ***HOLD Testing*** ***(pending MOH approval, insurance preauth, etc.)***

Comments/ Additional Clinical Information:

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Billing Instructions

1. Please choose one of the three billing options:

- ☐ Institutional
- ☐ Individual
- ☐ Insurance

2. Provide all information for the selected option only

Note: Patient testing will be delayed until all of the billing requirements have been met. Please print clearly. If Individual/Insurance billing information is incomplete, the Institution will be billed. Tests that are cancelled while in progress will be billed for the amount of work completed up to that point. If the patient's specimen is collected in New York, a New York State Non-Permitted Laboratory Test Request approval letter (see web site) must be included before testing will proceed.

1. Institutional Billing (Preferred)

Billing Institution		***PO Number***
Contact	***Phone Number(s)***	***Email***
Address		
City	***State***	***Zip***
Email Invoice **Email Address:**	***Copy of Test Report(s) for Billing*** ☐ **Secure Email (via ZixCorp):** ☐ **Other (please specify):**	

2. Individual Billing

Responsible Party's Name (Must be 18 years or older)	***Phone Number(s)***	***Email***
Address		
City	***State***	***Zip***

ACCEPTANCE OF FINANCIAL RESPONSIBILITY FOR GENETIC TESTING

Note: PreventionGenetics cannot proceed with testing of the specimen without a signature below.

My signature below indicates that I accept financial responsibility for all fees associated with this genetic testing order.

_____	_____	_____
Signature of Responsible Party	***Printed Name of Responsible Party***	***Date***

COMPLETE THE FOLLOWING FOR CREDIT CARD PAYMENT

Credit Card # / (VISA, Discover, or Mastercard only)	***Expiration Date***	***3-Digit Security Code***

My signature below authorizes PreventionGenetics to charge my credit card for services for which I am responsible.

Signature: ***Date:***

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Billing Instructions

3. Insurance Billing

We will file an insurance claim on behalf of the patient with any commercial insurance company. However, the claim will be submitted as an "out of network" service provider. We are in network (contracted provider) with a limited number of insurance plans (see website). The patient is responsible for any portion of the test fee not covered by the insurance company for any reason including, but not limited to, co-payments, co-insurance, unmet deductibles, or non-covered services.

Responsible Party's Name (Must be 18)	*Phone Number(s)*	*Email*

Responsible Party Address

City *State* *Zip*

Policyholder Name (Required)	*Please indicate the type of insurance: (Circle One)* *Private / Medicare / WI Medicaid** **We only accept WI Medicaid*	*Primary Insurance Company Name (Required)*

Insurance Company Address- Claims

City *State* *Zip*

ICD-10 Codes (Required)	*Policy ID#*	*Group #*	*Authorization #*

Please attach the following:

Note: PreventionGenetics cannot proceed with testing of the specimen until all information is received.

- ☐ ***NPI # of Requesting Physician _____***
- ☐ ***Medicare – signed ABN Form completed IN FULL***
- ☐ ***Copy of both sides of Insurance Card***
- ☐ ***Authorization number or letter of agreement from insurance company (if available). If not included, we will routinely perform pre-verification prior to initiating testing & will relay information to ordering provider.***
- ☐ ***Letter of Medical Necessity***
- ☐ ***Relevant Medical Records***
- ☐ ***NY Non-permitted lab approval letter (if specimen collected in NY)***
- ☐ ***Share results of benefits investigation with patient directly via email provided above or FAX# _____***

AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR MY ACCOUNT

Note: PreventionGenetics cannot proceed with testing of the specimen without a signature below.

I authorize PreventionGenetics to release information received including, without limitation, medical information, which includes laboratory test results, such as genetic tests results, to my health plan/insurance carrier and its authorized representatives. I further authorize insurance payments directly to PreventionGenetics for the services rendered. I understand my health plan/insurance/Medicare/Medicaid carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, medical necessity or otherwise. I understand I am financially responsible for fees not paid in full by my insurer, co-payments, and policy deductibles except where my liability is limited by contract or State and Federal law. I agree to help PreventionGenetics resolve any insurance claim issues.

_____ _____ _____

Signature of Patient or Guardian ***Printed Name of Patient or Guardian*** ***Date***

Credit Card # / (VISA, Discover, or Mastercard only)	*Expiration Date*	*3- Digit Security Code*

My signature below authorizes PreventionGenetics to charge my credit card for services for which I am responsible upon completion of insurance processing.

Signature: ***Date:***