PREVENTION GENETICS

PREVENTIONGENETICS USE ONLY

Test information is available on our website:
www.PreventionGenetics.com

All testing must be ordered by a qualified Healthcare Provider

THIS FORM MUST ACCOMPANY ALL SPECIMENS

This form should be used to request additional testing on existing samples.

ADD-ON TEST REQUISITION

PERSON COMPLETING FORM	CONTACT (PHONE OR EMAIL)	DATE OF REQUEST
		____ / ____ / ____ MONTH / DAY / YEAR

PATIENT INFORMATION

LAST (FAMILY) NAME	FIRST NAME	MI	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. If you have additional specific reporting requests, indicate them below.

☐ USE SAME ORDERING PROVIDER / REPORTING CONTACTS AS PREVIOUS ORDER.
☐ USE NEW ORDERING PROVIDER. PROVIDE CONTACT INFORMATION BELOW.

INSTITUTION

ADDRESS (City, State, Country and Postal Code)

REQUESTING PHYSICIAN, GENETIC COUNSELOR OR ALLIED PROVIDER (First, Last, Degree)

PHONE NUMBER	NPI#	EMAIL

SECURE EMAIL VIA ZIXCORP ☐ *Use above email address*

☐ DO NOT USE ZIXCORP. EMAIL RESULTS VIA SHAREFILE.
☐ DO NOT EMAIL RESULTS. Send via fax (provide fax number):_____

ADDITIONAL TEST SELECTION

List below the tests to be performed. Test Codes, Test Names and Turnaround Times (TAT) are available at www.PreventionGenetics.com. 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 based on sensitivity.

TEST ORDER	TEST CODE	TEST NAME
1		
2		
3		
4		

COMMENTS

SPECIAL INSTRUCTIONS

☐ **CONCURRENT TESTING**
All tests and genes ordered to be run simultaneously.

☐ **STAT TESTING**
For STAT testing add 25% to price. STAT testing is available for Sanger Sequencing and Gene-centric aCGH test. NextGen tests cannot be ordered STAT. STAT turnaround time is 8-10 calendar days. If TAT is not met, surcharge will be waived. Tests will run concurrently unless otherwise instructed.

☐ **HOLD TESTING**
Pending MOH approval, insurance pre-authorization, etc.

☐ **SPECIMEN COLLECTED IN NEW YORK STATE**
Include New York State Non-Permitted Laboratory Test Request approval letter if test is not NY state approved and Genetic Testing Healthcare Provider Statement. For a list of tests that are NY state approved see website.

☐ **POSITIVE CONTROL ONLY**
No charge / No report

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BILLING - PLEASE SELECT INSTITUTIONAL OR SELF-PAY WITH OPTION TO SUBMIT TO INSURANCE

PATIENT TESTING WILL BE DELAYED UNTIL ALL OF THE BILLING REQUIREMENTS HAVE BEEN MET. PLEASE PRINT CLEARLY.

If the patient's specimen is collected in New York, a New York State Non-Permitted Laboratory Test Request approval letter (where applicable) and Genetic Testing Healthcare Provider Statement (see website) must be included before testing will proceed.

INSTITUTIONAL BILLING

BILLING INSTITUTION		PO NUMBER	
CONTACT	PHONE NUMBER	EMAIL	
ADDRESS	CITY	STATE	ZIP
BILLING ACCOUNT NUMBER ☐ UPDATED INFO		COPY OF TEST REPORT(S) FOR BILLING	
EMAIL INVOICE VIA ZIXCORP (PROVIDE EMAIL ADDRESS)		☐ EMAIL (VIA ZIXCORP) _____	
		☐ OTHER (PLEASE SPECIFY) _____	

SELF-PAY **THIS SECTION MUST BE FILLED OUT COMPLETELY**

RESPONSIBLE PARTY'S NAME *(MUST BE 18 YEARS OR OLDER)*	PHONE NUMBER	EMAIL	
ADDRESS	CITY	STATE	ZIP

ACCEPTANCE of financial responsibility for genetic testing ***PREVENTIONGENETICS CANNOT PROCEED WITH TESTING OF THE SPECIMEN WITHOUT A SIGNATURE BELOW.***

My signature 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 NUMBER (VISA, DISCOVER, OR MASTERCARD ONLY)	EXPIRATION DATE	3-DIGIT SECURITY CODE

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

SIGNATURE _____ DATE _____

☐ SUBMIT CLAIM TO INSURANCE (OPTIONAL)

POLICYHOLDER'S NAME (REQUIRED)		PLEASE INDICATE THE TYPE OF INSURANCE ☐ PRIVATE ☐ MEDICARE ☐ WI MEDICAID *We only accept WI Medicaid*	
PRIMARY INSURANCE COMPANY NAME (REQUIRED)			☐ *ATTACH A COPY OF INSURANCE CARD both sides*
INSURANCE COMPANY ADDRESS - CLAIMS		CITY	STATE / ZIP
ICD-10 CODES (REQUIRED)	POLICY ID#	GROUP #	AUTHORIZATION #

PLEASE ATTACH THE FOLLOWING DOCUMENTATION *PreventionGenetics cannot proceed with testing of the specimen until all information is received.*

- ☐ NPI # of Requesting Physician _____
- ☐ *MEDICARE – signed ABN Form completed IN FULL*
- ☐ *AUTHORIZATION NUMBER* or letter of agreement from Insurance Company (if available). If not included, we will routinely perform pre-verification prior to initiating testing and will relay information to ordering provider.
- ☐ *Relevant Medical Records addressing medical necessity and/or Letter of Medical Necessity*
- ☐ *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

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. My signature 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 _____