

All testing must be ordered by  
a qualified Healthcare Provider

PREVENTIONGENETICS USE ONLY

**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 ____ / ____ / ____ <small>MONTH DAY YEAR</small>
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## PATIENT INFORMATION

LAST (FAMILY) NAME	FIRST NAME	MI	DATE OF BIRTH ____ / ____ / ____ <small>MONTH DAY YEAR</small>
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
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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	SPECIAL INSTRUCTIONS
1			<input type="checkbox"/> <b>CONCURRENT TESTING</b> All tests and genes ordered to be run simultaneously. <input type="checkbox"/> <b>STAT TESTING</b> 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. <input type="checkbox"/> <b>HOLD TESTING</b> Pending MOH approval, insurance pre-authorization, etc. <input type="checkbox"/> <b>SPECIMEN COLLECTED IN NEW YORK STATE</b> 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. <input type="checkbox"/> <b>POSITIVE CONTROL ONLY</b> No charge / No report
2			
3			
4			

COMMENTS

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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.

<b>INSTITUTIONAL BILLING</b>		BILLING INSTITUTION		PO NUMBER
CONTACT	PHONE NUMBER	EMAIL		
ADDRESS	CITY	STATE	ZIP	
BILLING ACCOUNT NUMBER <input type="checkbox"/> UPDATED INFO	<b>COPY OF TEST REPORT(S) FOR BILLING</b>			
<b>EMAIL INVOICE VIA ZIXCORP (PROVIDE EMAIL ADDRESS)</b>	<input type="checkbox"/> EMAIL (VIA ZIXCORP) _____			
	<input type="checkbox"/> OTHER (PLEASE SPECIFY) _____			

<b>SELF-PAY</b>					<b>**THIS SECTION MUST BE FILLED OUT COMPLETELY**</b>				
RESPONSIBLE PARTY'S NAME (MUST BE 18 YEARS OR OLDER)				PHONE NUMBER		EMAIL			
ADDRESS				CITY		STATE		ZIP	
<b>ACCEPTANCE of financial responsibility for genetic testing</b> <b>PREVENTIONGENETICS CANNOT PROCEED WITH TESTING OF THE SPECIMEN WITHOUT A SIGNATURE BELOW.</b> 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 _____						
<input type="checkbox"/> <b>SUBMIT CLAIM TO INSURANCE (OPTIONAL)</b>									
POLICYHOLDER'S NAME (REQUIRED)				PLEASE INDICATE THE TYPE OF INSURANCE					
				<input type="checkbox"/> PRIVATE <input type="checkbox"/> MEDICARE <input type="checkbox"/> WI MEDICAID <i>We only accept WI Medicaid</i>					
PRIMARY INSURANCE COMPANY NAME (REQUIRED)						<input type="checkbox"/> 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 <i>PreventionGenetics cannot proceed with testing of the specimen until all information is received.</i>									
<input type="checkbox"/> NPI # of Requesting Physician _____			<input type="checkbox"/> Relevant Medical Records addressing medical necessity and/or Letter of Medical Necessity			<input type="checkbox"/> SHARE RESULTS of benefits investigation with patient directly via email provided above			
<input type="checkbox"/> MEDICARE – signed ABN Form completed IN FULL									
<input type="checkbox"/> 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.			or FAX # ( _____ ) _____ - _____						
<b>AUTHORIZATION to assign benefits and accept financial responsibility for my account</b> <b>PREVENTIONGENETICS CANNOT PROCEED WITH TESTING OF THE SPECIMEN WITHOUT A SIGNATURE BELOW.</b>									
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 _____			