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

Breast & Colon Cancer Test Requisition Form

(revised 12/30/16)

Testing must be ordered by a qualified healthcare provider. Test information is available at www.preventiongenetics.com.

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

Patient Information

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

Patient ID Code	*Date Collected:* Month Day Year	*Sex:* ☐ Male ☐ Female ☐ Other *Karyotype:*

Specimen Source:
☐ *Whole blood* ☐ *Extracted DNA Source:* ☐ *Cultured Cells Source:* ☐ *Tissue Source:* ☐ *Other:*

Reason for test	*GeoAncestry/Ethnicity*	*Has patient been tested previously at PreventionGenetics?*	*Has patient's relative been tested at PreventionGenetics?*	*Ongoing pregnancy?*
☐ Diagnosis ☐ Presymptomatic/ At risk ☐ Carrier Testing		☐ Yes ☐ No *If yes, PG ID#:*	☐ Yes ☐ No *If yes, provide name & DOB:*	☐ Yes ☐ No Prenatal Healthcare Statement required for fetal testing.

Has patient had a blood transfusion within the last month?	*Has patient had a bone marrow transplant?*	*Other relevant clinical information (Labs, biopsies, other genetic testing performed, etc). Please attach pedigree if possible.*
☐ Yes ☐ No *If yes, provide type & date:*	☐ Yes ☐ No	

Test Selection

Please select the tests that are to be performed. The Test Descriptions and turnaround time can be obtained from our web site. Please include any special test instructions in the comments section. The tests will be performed in the order listed unless otherwise specified.

Test Selection:

BREAST

☐ *Test Code 1949 BRCA1/2*
☐ *Test Codes 1307 Expanded HBOC Panel*
☐ *Test Code 1305 High Risk HBOC Panel*

COLON

☐ *Test Code 1975 Colorectal Cancer Panel*
☐ *Test Code 1325 Lynch Syndrome Panel*

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

If other tests are desired, please use Standard Test Requisition Form.

Comments:

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Provider/Laboratory Contact Information

- **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, please indicate them below.**

Provider Information			
Institution			
Address (please include city, state, country & postal code)			
Requesting Physician (First, Last, Degree)		***Requesting Genetic Counselor (First, Last, Degree)***	
Phone Number	***NPI#:***	***Phone Number***	***NPI#***
Email		***Email***	
Test Reporting Instructions *Our preferred method of report transmission is email (via ZixCorp)*		**Test Reporting Instructions** *Our preferred method of report transmission is email (via ZixCorp)*	
Secure Email (via ZixCorp): ☐ *use above*		***Secure Email (via ZixCorp):*** ☐ *use above*	
☐ ***DO NOT use ZixCorp. Instead, send email via ShareFile.***		☐ ***DO NOT use ZixCorp. Instead, send email via ShareFile.***	
☐ ***DO NOT email results. Instead, send via fax (provide fax #):***		☐ ***DO NOT email results. Instead, send via fax (provide fax #):***	

Sendout Laboratory (Complete only if report needed)	**Other**
Laboratory & Contact Person	***Contact Name***
Address	***Address***
Phone Number	***Phone Number***
Email	***Email***
Test Reporting Instructions *Our preferred method of report transmission is email (via ZixCorp)*	**Test Reporting Instructions** *Our preferred method of report transmission is email (via ZixCorp)*
Secure Email (via ZixCorp): ☐ *use above*	***Secure Email (via ZixCorp):*** ☐ *use above*
☐ ***DO NOT use ZixCorp. Instead, send email via ShareFile.***	☐ ***DO NOT use ZixCorp. Instead, send email via ShareFile.***
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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 (Breast & Colon Cancer)

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 co-payments, co-insurance, unmet deductibles, or non-covered services. If PreventionGenetics performs pre-authorization, we will notify the patient to inform them of these amounts.

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 assign and authorize insurance payments to PreventionGenetics. I understand my insurance/medicare/medicaid carrier may not approve and reimburse my medical genetic services in full due to benefit exclusions, coverage limits, lack of authorization, medical necessity or otherwise. I understand I am responsible for co-payments, co-insurance, unmet deductibles, or non-covered services 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:***

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Specimen Requirements, Shipping Instructions & More Information

Specimen Requirements
Next-Gen Sequencing with Deletion/Duplication via aCGH (Great majority of tests completed within 28 days.)

WHOLE BLOOD: Collect 3-5 ml of whole blood in EDTA (purple top tube) or ACD (yellow top tube), minimum 1 ml.

DNA: Send in screw cap tube at least 10 µg of purified DNA at a concentration of at least 100 µg/ml (indicate concentration on tube label).

SKIN FIBROBLAST CELL CULTURE & FRESH, FROZEN TISSUE: Please contact us for details.

SALIVA: Oragene™ Saliva Collection kit used according to manufacturer instructions.

Shipping/Handling Instructions

Please label all specimen containers with the patient's name, date of birth and/or ID number. At least two identifiers should be listed on specimen containers. We accept specimen deliveries Monday-Saturday for all specimen types except cell cultures. Cell culture deliveries are routinely accepted Monday-Thursday and require advance notice of arrival.

BLOOD: Do not freeze. During hot weather, include a frozen ice pack in the shipping container. Place a paper towel or other thin material between the ice pack and the blood tube. In cold weather include an unfrozen ice pack in the shipping container as insulation. At room temperature, blood specimen is stable for up to 48 hours. If refrigerated, blood specimen is stable for up to one week.

DNA: DNA may be shipped at room temperature. Label the tube with the composition of the solute, DNA concentration as well as the patient's name, date of birth, and/or ID number. We only accept genomic DNA for testing. We do NOT accept products of whole genome amplification reactions or other amplification reactions.

CELL CULTURES: We are NOT able to culture cells. Send confluent flasks of cultured cells in insulated, shatterproof container overnight. Cell cultures may be shipped at room temperature or refrigerated.

Address	**Testing Kits**
Diagnostic Lab PreventionGenetics 3800 S. Business Park Ave. Marshfield, WI 54449 USA	Clinical testing kits with prepaid return shipping are now available for our U.S. clients. We are able to provide Clinical Testing Kits to our international clients without the return postage at this time. To order kits, submit requests through our Electronic Order Form on our web site or contact our Client Service Representatives at 715-387-0484, ext. 0.

DNA Genotyping Panel

For quality control purposes, the PreventionGenetics DNA Genotyping Panel is performed on all clinical specimens. Genotyping results are ***not*** included in test reports.

DNA Banking

DNA Banking has a reduced price of $98 for patients if clinical testing is also being performed with us. For DNA Banking, see our DNA Banking Process and DNA Banking Forms. For questions related to DNA Banking, contact our DNA Banking Director at 715-387-0484, ext. 151 or email dnabanking@preventiongenetics.com.