PREVENTION GENETICS part of EXACT SCIENCES

Test information is available on our website:
PreventionGenetics.com

PREVENTIONGENETICS USE ONLY

RESET FORM

All testing must be ordered by a qualified Healthcare Provider

A completed online order **OR** paper TRF and labeled specimen is required to initiate testing.

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

This form cannot be utilized for PGxome and PGnome tests, due to the complexity of information (including detailed clinical information) required. Submit completed PGxome or PGnome test requisitions to add on these tests.

ADD-ON TEST REQUISITION

PERSON COMPLETING FORM	CONTACT (DIRECT PHONE OR EMAIL)	DATE OF REQUEST (MM/DD/YYYY)

PATIENT INFORMATION

LAST (FAMILY) NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YYYY)

PATIENT ID CODE	PG ID#	ICD-10 CODES
		1 _____ (PRIMARY) 2 _____ 3 _____

TEST SELECTION

List below the tests to be performed. PGxome and PGnome require completion of the full PGxome or PGnome Test Requisition form.
Test Codes, Test Names and Turnaround Times (TAT) are available at www.PreventionGenetics.com.

The tests will be performed concurrently unless otherwise specified. Include any special test instructions in the comments section.

TEST CODE	TEST NAME	ORDER OPTIONS
		☐ Patient Only ☐ Family - Duo ☐ Family - Trio ☐ Include family/comparator demographics (name, DOB, ID#, and relationship) on the proband report.
		☐ Patient Only ☐ Family - Duo ☐ Family - Trio ☐ Include family/comparator demographics (name, DOB, ID#, and relationship) on the proband report.

COMMENTS

SPECIAL INSTRUCTIONS

☐ **ADD EXOME-WIDE CNV ANALYSIS $250,** CPT CODE 81479

With an order for any PGxome-based or custom panel, exome-wide CNV analysis is available as an add on. To confirm if this is an option for your order, visit the panel-specific description on our website. Unavailable for PG-Select panels, Sanger sequencing, and other test methods. To learn more, visit the Test Methods page on our website under Resources.

☐ **STAT TESTING**

STAT surcharge adds 25% to price. STAT surcharge will not apply if report is delivered after 16 days and blood sample was submitted.

☐ **HOLD TESTING - PENDING**

☐ Funding approval (e.g. MOH)
☐ Other:

☐ **REFLEXIVE TESTING**

Checking this box indicates you would like all ordered testing to be performed in the order listed.

☐ **SPECIMEN COLLECTED IN NEW YORK STATE**

Include New York State Genetic Testing Healthcare Provider Statement and New York State Non-Permitted Laboratory Test Request approval letter if test is not NY state approved. For a list of NY state approved tests, see website.

PROVIDER / LABORATORY CONTACT AND REPORTING

Our preferred method of report transmission is uploading to our secure web portal, myPrevent.

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	ZIP

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

EMAIL ADDRESS (For report access via myPrevent)	EMAIL ADDRESS (For report access via myPrevent)

PHONE NUMBER	NPI# (US only)	PHONE NUMBER	NPI# (US only)

IF YOU REQUIRE REPORTS TO BE TRANSMITTED VIA ANOTHER SECURE METHOD, SPECIFY HERE.

LIST ADDITIONAL HEALTHCARE PROVIDERS AND THEIR EMAILS TO ALLOW ACCESS TO REPORTS

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PATIENT

LAST NAME

FIRST NAME | MI

BILLING

PATIENT TESTING WILL PROCEED WHEN ALL BILLING INFORMATION HAS BEEN RECEIVED.

BILLING INSTITUTION | PO NUMBER

CONTACT | PHONE NUMBER | EMAIL

ADDRESS | CITY | STATE | ZIP

BILLING ACCOUNT NUMBER ☐ UPDATED INFO

EMAIL INVOICE VIA SECURE EMAIL (provide email address)

ACCESS TO TEST REPORT(S) FOR BILLING

☐ EMAIL ADDRESS (For report access via myPrevent) _____

☐ OTHER (specify) _____

COMPLETE THIS SECTION FOR PATIENT PAY AND/OR INSURANCE BILLING

**** THIS SECTION MUST BE FILLED OUT COMPLETELY ****

RESPONSIBLE PARTY'S NAME *(MUST BE 18 YEARS OR OLDER)* | PHONE NUMBER

ADDRESS | CITY | STATE | ZIP

EMAIL

ACCEPTANCE of financial responsibility for genetic testing

SIGNATURE REQUIRED BELOW TO PROCEED WITH TESTING.

MY SIGNATURE INDICATES I ACCEPT FINANCIAL RESPONSIBILITY FOR ALL FEES ASSOCIATED WITH THIS GENETIC TESTING ORDER.
If applicable, 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. I understand my out-of-network benefits may apply. PreventionGenetics may contact me to resolve any billing-related issues and to request payment.

SIGN HERE: Required to process form

PATIENT / RESPONSIBLE PARTY SIGNATURE | PRINTED NAME OF RESPONSIBLE PARTY | DATE

CREDIT CARD PAYMENT

- **PATIENT PROMPT PAY (excludes insurance billing)**
  Card information provided below will be charged when specimen arrives. The 10% Patient Prompt Pay discount will apply.
- **PATIENT PAY - INSURANCE BILLING**
  Card information provided below will be charged when the claim is processed. The 10% Patient Prompt Pay discount **WILL NOT** apply.

CREDIT CARD INFORMATION

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.

SIGN HERE: Required to process credit card

CREDIT CARD HOLDERS SIGNATURE | DATE

INSURANCE INFORMATION - IF APPLICABLE

INDICATE THE TYPE OF INSURANCE ☐ **Attach a copy of Insurance Card (both sides)**

☐ **PRIVATE** ☐ **TRICARE** *include signed Tricare waiver* ☐ **MEDICARE** *include signed ABN form* ☐ **MEDICAID** *Visit PreventionGenetics.com for in-network Medicaid plans.*

POLICY HOLDER NAME | DATE OF BIRTH (MM/DD/YYYY) | RELATIONSHIP TO PATIENT

PRIMARY INSURANCE COMPANY NAME (REQUIRED) | PHONE NUMBER

POLICY ID# | GROUP # | AUTHORIZATION # ☐ *Attach copy of authorization, PreventionGenetics must be listed as servicing provider.*

SECONDARY INSURANCE ☐ **Attach a copy of Insurance Card (both sides)**

TESTING WILL PROCEED UNLESS:
- We (or you) are working on a required Pre-Authorization.
- No insurance coverage is available. We will work with you or your patient to determine payment options.

NOTE: Prenatal CMA, re-analysis, and cell cultures cannot be canceled once a sample is received. Testing placed on hold will extend overall TAT.

OR PLEASE PROVIDE YOUR PREFERENCES BELOW:

☐ **HOLD TESTING** for benefit investigation / pre-authorization and share results with patient directly via email provided.

☐ **PROCEED WITH TESTING:** patient accepts financial responsibility for test; regardless of insurance coverage.
(All tests with an in-network insurance are held for benefits investigation, regardless of selected option, except for prenatal and Rapid NICU tests.)

☐ **OTHER:** _____

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