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.

TARGETED VARIANT 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)

ADDRESS	CITY	STATE/PROVIDENCE	ZIP / POSTAL CODE

EMAIL	PHONE NUMBER	GEOANCESTRY / ETHNICITY

MEDICAL RECORD NUMBER (MRN)

BIOLOGICAL SEX
☐ Male ☐ Female ☐ Other, specify karyotype _____

REASON FOR TEST
☐ Diagnosis / Affected ☐ Presymptomatic / At Risk ☐ Carrier Testing / Unaffected

ONGOING PREGNANCY
☐ NO ☐ YES
For testing on a prenatal specimen from an ongoing pregnancy complete the Prenatal Test Requisition Form.

HAS PATIENT BEEN TESTED PREVIOUSLY AT PreventionGenetics?
☐ No
☐ Yes, PG ID# _____

BLOOD TRANSFUSION
☐ NO ☐ Within last 6 weeks, include date and type
DATE (MM/DD/YYYY) _____ TYPE _____

BONE MARROW TRANSPLANT
☐ NO ☐ Yes, include date
DATE (MM/DD/YYYY) _____

HAS PATIENT'S RELATIVE BEEN TESTED? ☐ NO ☐ YES - at PreventionGenetics, include:

RELATIVE'S NAME AND/OR PreventionGenetics ID NUMBER _____ DATE OF BIRTH (MM/DD/YYYY) _____ RELATIONSHIP TO PATIENT _____

ICD-10 CODES
(REQUIRED FOR INSURANCE BILLING) 1 PRIMARY _____ 2 _____ 3 _____

RELEVANT CLINICAL INFORMATION. We require the inclusion of detailed clinical notes/completion of the **clinical features checklist** and a pedigree. The ability to interpret variants directly correlates with the quality of clinical information provided. ☐ Clinical records attached.

SPECIMEN INFORMATION

SPECIMEN SOURCE
☐ Whole Blood ☐ Direct CVS ☐ Tissue, Source _____
☐ Saliva ☐ Direct Amniotic Fluid ☐ Extracted DNA, Source _____
☐ Buccal ☐ Cultured Cells, Source _____ ☐ Other _____

SPECIMEN COLLECTION DATE
(MM/DD/YYYY)

If no collection date is provided, date of receipt will be used.

☐ **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.

TEST SELECTION

PreventionGenetics offers no-cost targeted testing for certain variants classified as a varient of uncertyan signifigance (VUS) in parents of probands tested at our laboratory in order to assist with clarifying interpretation of variants. See our Family Targeted Variant Testing Policy on our website for more information.

Positive Control If the family member was tested at an outside laboratory, we recommend you submit the outside report and a specimen from the individual to serve as a positive control. If a positive control is not provided, negative results will carry a limitation stating PreventionGenetics did not have the opportunity to verify that we can detect the variant in this family. Please contact client services with questions.

TEST CODE	GENE(S)	VARIANT(S) OR COMMENTS
☐ **100** (1 variant)		
☐ **200** (2 variants)		
☐ **300** (3 variants)		
☐ **1400** (Known Familial del/dup, PCR) only available for family members of probands who were tested at PreventionGenetics and if we confirmed the del/dup by PCR		
☐ **600** (Del/Dup via aCGH)		
☐ **Other** _____ SPECIFY TEST CODE		

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.

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PATIENT

LAST NAME

FIRST NAME | **MI**

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.

PROVIDER INFORMATION

INSTITUTION

ADDRESS | **CITY** | **STATE** | **ZIP**

REQUESTING PHYSICIAN (First, Last, Degree)

EMAIL ADDRESS (For report access via myPrevent)

PHONE NUMBER | **NPI#**

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

EMAIL ADDRESS (For report access via myPrevent)

PHONE NUMBER | **NPI#**

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

As the ordering Healthcare Provider, I certify that: (1) I have obtained the patient's informed consent and family member's informed consent (as applicable) to perform this test as documented on a signed consent form that complies with applicable law and is consistent, in all material respects, with PreventionGenetics' Informed Consent form (available at https://assets.preventiongenetics.com/documents/patient-informed-consent.pdf), which I will maintain on file and make available to PreventionGenetics upon request; (2) The patient and their family member (as applicable) have been appropriately counseled and understand the risks, benefits, and limitations of this genetic testing and the implications of the results; and (3) I have received the patient's and family member's (as applicable) consent for PreventionGenetics to use and disclose information, test results, and sample as described in the consent form.

SEND OUT LABORATORY

COMPLETE ONLY IF REPORT IS NEEDED

INSTITUTION / CONTACT

ADDRESS | **CITY** | **STATE** | **ZIP**

EMAIL ADDRESS (For report access via myPrevent)

PHONE NUMBER

NPI# (where applicable)

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

ADDITIONAL ACCESS TO REPORTS List additional Healthcare Providers and their emails to allow access to reports

INSTITUTION BILLING

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

IF INSTITUTIONAL BILLING IS SELECTED, PAGE 3 IS NOT REQUIRED.

☐ Send invoice to the contact information above. Please provide PO number below if applicable.

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) _____

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PREVENTIONGENETICS USE ONLY

PATIENT

LAST NAME

FIRST NAME | MI

COMPLETE THIS FORM FOR PATIENT PAY AND/OR INSURANCE BILLING

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

** 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.

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:** _____

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