

TARGETED VARIANT TEST REQUISITION

PERSON COMPLETING FORM	CONTACT (DIRECT PHONE OR EMAIL)	DATE OF REQUEST (MM/DD/YYYY)
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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 ☐ Saliva ☐ Direct Amniotic Fluid ☐ Buccal ☐ Cultured Cells, Source _____	☐ Tissue, Source _____ ☐ Extracted DNA, 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.
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TEST SELECTION

PreventionGenetics offers no-cost targeted testing for certain variants classified as a variant of uncertain significance (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

☐ NO CHARGE <i>Meets Family Targeted Variant Testing policy or included in test 990</i>	☐ STAT TESTING <i>STAT surcharge adds 25% to price. STAT surcharge will not apply if report is delivered after 16 days and blood sample was submitted.</i>	☐ HOLD TESTING - PENDING ☐ Funding approval (e.g. MOH) ☐ Other:
☐ POSITIVE CONTROL ONLY <i>No charge / No report</i>		

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)		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#	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	ACCESS TO TEST REPORT(S) FOR BILLING		
☐ EMAIL ADDRESS (For report access via myPrevent) _____			
☐ OTHER (specify) _____			

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
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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.