

# MOLECULAR GENETICS CARRIER SCREEN & DIAGNOSTIC REQUISITION

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<p><b>PATIENT INFORMATION</b> (PLEASE PRINT IN BLACK INK)</p> <hr/> <p>Last Name _____ First _____ MI _____</p> <hr/> <p>Address _____ Birth Date _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <hr/> <p>City _____ SS # _____</p> <hr/> <p>State _____ Zip _____ Home Phone _____</p> <hr/> <p>Hospital/Physician Office Patient ID # _____ Accession # _____</p> <p><small>MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.</small></p> <p><b>INSURANCE BILLING INFORMATION</b> (PLEASE ATTACH CARD OR PRINT IN BLACK INK)</p> <p><b>BILL TO:</b> <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p><b>PATIENT STATUS:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p><b>PRIMARY:</b> <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child</p> <hr/> <p>Subscriber Last Name _____ First _____ MI _____</p> <hr/> <p>Beneficiary / Member # _____ Group # _____</p> <hr/> <p>Claims Address _____ City _____ State _____ Zip _____</p> <p><b>SECONDARY:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach) <b>ABN:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p><b>DIAGNOSIS CODE (REQUIRED)</b> ICD-10 Codes 1. _____ 2. _____ 3. _____</p>	<p style="text-align: center;"><b>CLIENT INFORMATION</b></p> <hr/> <p><b>ORDERING PHYSICIAN CONTACT</b></p> <p>Physician Name _____</p> <hr/> <p>Physician NPI# _____</p> <hr/> <p>Physician Phone _____</p> <hr/> <p>Physician Email _____</p> <p><input type="checkbox"/> Call Results to phone number: ( _____ ) _____</p> <p><input type="checkbox"/> Fax report to: ( _____ ) _____</p> <hr/> <p><b>SAMPLE REQUIREMENT</b></p> <p>Requires 1 EDTA 4 mL tube, lavender</p> <p>Collection Date: ____/____/____ Time: _____</p>																
<p><b>INDICATE TESTS REQUESTED</b></p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;"></th> <th style="width:15%; text-align: center;"><i>Carrier Screen</i></th> <th style="width:15%; text-align: center;"><i>Diagnostic Test</i></th> <th style="width:10%; text-align: center;"><i>CPT Code</i></th> </tr> </thead> <tbody> <tr> <td>Spinal Muscular Atrophy <i>SMA12</i></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">81401/G0452</td> </tr> <tr> <td>Cystic Fibrosis Pathogenic Variant Analysis <i>CFMDX</i></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">81220/G0452</td> </tr> <tr> <td>Fragile X Syndrome DNA Analysis by PCR, Blood <i>FRAX</i></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">81243/G0452</td> </tr> </tbody> </table>			<i>Carrier Screen</i>	<i>Diagnostic Test</i>	<i>CPT Code</i>	Spinal Muscular Atrophy <i>SMA12</i>	<input type="checkbox"/>	<input type="checkbox"/>	81401/G0452	Cystic Fibrosis Pathogenic Variant Analysis <i>CFMDX</i>	<input type="checkbox"/>	<input type="checkbox"/>	81220/G0452	Fragile X Syndrome DNA Analysis by PCR, Blood <i>FRAX</i>	<input type="checkbox"/>	<input type="checkbox"/>	81243/G0452
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