LAB GENOMICS

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CLIA # 055D2026572

PREDICTIVE | PREVENTATIVE | PERSONALIZED

Test(s) Requested

☐ **Pain Management**
(CYP2D6, CYP2C19, CYP2C9, CYP3A4, CYP3A5, CYP1A2, CYP2B6,OPRM1)

☐ **Orthopedic Panel** (2D6,2C19, 2C9, 3A4, 3A5,FactorII, Factor V, MTHFR, VKOR1

☐ **Urology Panel** (2D6 ,3A4,3A5)

☐ **Cardiovascular Panel**
(ApoE, CYP2D6, CYP2C19, 2C9-VKORC1,
Factor II, Factor V, MTHFR, CYP3A4, CYP3A5, SLCO1B1, ITGB3, LPA, 9P21)

☐ **Comprehensive panel**
(ApoE, CYP2D6, CYP2C19, 2C9-VKORC1,OPRM1,COMT, ITGB3
Factor II, Factor V, MTHFR, CYP3A4,CYP3A5, CYP1A2, CYP2B6, SLCO1B1, LPA, 9P21

☐ **Will submit feedback as to the effects on the patient's overall health when actions based on the test are taken**

☐ **Re-Swab**
Other:_____

Patient Information

Last Name _____**First Name**_____

Address _____

City_____ **State** _____ **Zip**_____

Telephone: (_____) - _____ - _____

Social Security Number_____

Date of Birth _____/_____/_____

Gender: ☐ Male ☐ Female

Race/Ethnic Identification:
☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic
☐ Other_____

ICD-10 Code: (Required)

Test Results Delivery

Check at least one box below for result delivery for this test (Lab **WILL NOT** distribute results to patient)

To Insure Integrity, Compliance, & Privacy of Testing

A Secure Box Account is required for delivery of all test.

☐ Box.com Email Invite_____

Encrypted email

☐ E-mail results to: _____

Ordering Physician Information

Physician Name _____

NPI Number _____

Practice _____

Office Phone _____

Office E-mail_____

Name of office contact for insurance billing questions:

_____

Physician / Authorizing Medical Professional's Signature

X _____

Insurance Information

Please include photocopy of all insurance cards:

☐ **Medicare** ☐ **Medicaid** ☐ **Self Pay**

☐ **Insurance**

☐ **Pre-Authorization form Attached**

Policy #_____

Collection Information

Collection Date: _____ / _____ /_____

Collection Time:_____:_____ ☐ am ☐ pm

Initials of person collecting sample: _____

Type of Sample Submitted:

☐ Swabs rubbed firmly in each cheek and under the gum

Specifically, the tests ordered herein are Medically necessary for this particular patient, given the patient's clinical condition, because the test assist in the:

☐ Determination of the efficacy of existing medications

☐ Assessment of pt's past adverse drug reaction

☐ Determination of the efficacy of potential or planned medications

☐ Planned treatment of the patient

☐ Assessment of potential adverse drug reaction on one or more of the pt's attributes ☐ Other: _____

Patient Consent: I request and authorize a CLIA certified laboratory to perform the above designated test(s) on the DNA sample provided by me. My signature below constitutes my acknowledgement that I have been informed of the benefits and limitations of this testing which have been explained to my satisfaction by a qualified health professional

Assignments of Benefits: I hereby authorize Lab Genomics LLC, to bill my insurance company and receive payment from them on my behalf. I acknowledge, however, that I am responsible for payment of my account and any and all charges associated with its collection.

Appeal Authorization: In the event of an underpayment or denial by my insurance carrier, I hereby authorize Lab Genomics LLC or their designee, to appeal my health plan on my behalf. (1) to provide the actions and information necessary to overturn the denial or receive reimbursement for the underpaid claim. The authorization shall remain in valid until the charges for the orders on this form are paid in full.

((1) Lab Genomics LLC and or designee may perform this appeal on my behalf, but is not obligated to do so)

The Laboratory hereby advises the physician or other authorized individual that Medicare will only pay for test that are reasonable and necessary to treat or diagnose an individual patient (see section 1862(a)(1)A) of the Social Security Act). Medicare does not cover routine screening tests. The physician or authorized individual attests that the tests ordered are reasonable and necessary for the patient. The physician or authorized individual agrees to provide access to medical records to laboratory in order to document said medical necessity.

Patient Signature: _____Date: _____