LAB GENOMICS

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CLIA # 055D2026572

PREDICTIVE | PREVENTATIVE | PERSONALIZED

Reproductive Genetics

Test(s) Requested

☐ **CFTR**
139 varients FDA cleared assay for Cystic Fibrosis
EDTA whole blood sample
(Cystic Fibrosis consent form required)

☐ **Parent-to-Be-Carrier**
Various diseases including Tay-Sachs, Fragile X, and SMA
EDTA whole blood sample
(Parent-to-Be-Carrier Screening consent form required)

☐ **PGS: 24 Chromosome Analysis on Embryo Biopsy**
With most accurate NGS Method
Number of Embryo: _____ (PGS consent form required)

☐ **Determine10 NIPT: Sequencing By Synthesis**
Weeks of Gestation: _____ ☐ Sex Chromosome
Last Menstral Period: _____ ☐ Microdeletion
Streck cell free DNA Blood sample (Determine10 consent form required)

☐ **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 test result delivery for this test
(Lab WILL NOT distribute test results to patient).

To Insure Integrity, Compliance, & Privacy of Testing
A Secure Box Account is required for delivery for all tests.

☐ Box.com Email Invite: _____

☐ Encrypted Email results to:_____

Ordering Physician Information

Physician Name _____

NPI Number _____

Practice _____

Office Phone _____

Office Fax _____

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:

☐ **EDTA sample** ☐ **Streck Cell Free DNA blood sample** ☐ **Embryo Biopsy**

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

☐ Advance maternal age
☐ Positive serum screen
☐ Abnormal ultrasound
☐ History suggestive of increased risk for the specified chromosome aneuploidies
☐ Low risk/maternal anxiety
☐ 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 responsible 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: _____