LAB GENOMICS

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Fountain Valley, Ca 92708
Phone: (714) 438-1009 Fax: (714) 438-2484
CLIA # 05D2026572

PREDICTIVE | PREVENTATIVE | PERSONALIZED

Test(s) Requested

PHARMACOGENETICS:

☐ 400 Comprehensive Panel

☐ 500 Pain Panel

☐ 600 Psychiatric Panel

☐ 700 Cardio Vascular Panel

☐ 900 Urology Panel

INFECTIOUS DISEASES:

☐ 7000 Respiratory Panel - RP

☐ 8000 Gastro-Intestinal Panel - GI

☐ **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 result.

☐ Box.com Email Invite________________________________

Encrypted email
☐ E-mail 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:

☐ Viral transport Media (Respiratory Panel) ☐ Cary Bair transport media (GI panel)

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: ______________________________________