PREVENTION GENETICS

DISEASE PREVENTION THROUGH GENETIC TESTING

Office use only

3800 S. Business Park Ave
Marshfield, WI 54449
Phone: 715-387-0484
Fax: 715-384-3661

Test Requisition Form

(revised 10/01/2015)

- This form must accompany all specimens.
- Billing instructions are on pages 3-4.
- Specimen and shipping instructions are on pages 5-6.
- Test information is available from our web site (www.preventiongenetics.com).
- All testing must be ordered by a qualified healthcare provider.

Person completing form	*Contact Information (phone or email)*	*Date of Request*

Patient Information

Patient's Last (Family) Name	*First Name*	*MI*	*Date of Birth:* Month Day Year

Patient ID Code	*Date Collected:* Month Day Year	*Gender:* ☐ Male ☐ Female ☐ Other *Karyotype:*

Specimen Source:
☐ *Whole blood* ☐ *Extracted DNA Source:* ☐ *Cultured Cells Source:* ☐ *Tissue Source:* ☐ *Direct Amnio* ☐ *Direct CVS* ☐ *Other:*

Reason for test	*GeoAncestry/ Ethnicity*	*Has patient been tested previously at PreventionGenetics?*	*Has patient's relative been tested at PreventionGenetics?*	*Ongoing pregnancy?*	*Bone marrow transplant or blood transfusion?*
☐ Diagnosis ☐ Presymptomatic/ At risk ☐ Carrier Testing		☐ Yes ☐ No *If yes, PG ID#:*	☐ Yes ☐ No *If yes, provide name & DOB:*	☐ Yes ☐ No Prenatal Healthcare Statement required.	☐ Yes ☐ No *If yes, date:*

Other relevant clinical information (Labs, biopsies, other genetic testing performed, etc). Please attach pedigree if possible.

Test Selection

Please list below the tests that are to be performed. The Test Numbers and Names, and turn around time can be obtained from our web site preventiongenetics.com. Please include any special test instructions in the comments section. The tests will be performed in the order listed unless otherwise specified. Unless specifically requested we will run Sanger panels sequentially as listed in our test descriptions. We offer a STAT option on our tests with ≤10 calendar day turnaround for Sanger sequencing tests. We cannot guarantee STAT TAT for gene-centric aCGH (Test Code 600) and will only charge STAT surcharge if testing is completed within 10 days. NextGen panels are not currently available to be ordered STAT.

Test Order	*Test Code*	*Test Name*
1	482,CPT 81479	LIPA Sanger Sequencing
2		
3		
4		
5		

Special Instructions

☐ ***Concurrent Testing Requested (All tests ordered, including genes within panels, to be run simultaneously.)***

☑ ***STAT Testing Requested.* (For STAT add 25% to price. Tests ordered will be run concurrently unless otherwise instructed.)***

**** See paragraph above for limitations.***

Comments:

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Provider/Laboratory Contact Information

- **Our preferred method of report transmission is email (via ShareFile). Please provide an email address when possible.**
- **If you have additional specific reporting requests, please indicate them below.**

Provider Information			
Institution GenoPheno, LLC			
Address (please include city, state, country & postal code) 1 Solla Sollew Way, Whoville, ME 11011			
Requesting Physician (First, Last, Degree) Dr Theodore Geisel		***Requesting Genetic Counselor (First, Last, Degree)***	
Phone Number _1(234)567-8910	***NPI#:*** 1212121212	***Phone Number***	***NPI#***
Email		***Email***	
Test Reporting Instructions *Our preferred method of report transmission is email (via ShareFile)*		**Test Reporting Instructions** *Our preferred method of report transmission is email (via ShareFile)*	
Email (via ShareFile): ☐ *use above*		***Email (via ShareFile):*** ☐ *use above*	
☑ ***DO NOT email results. Instead, send via fax (provide fax #):*** 1(234)567-8912		☐ ***DO NOT email results. Instead, send via fax (provide fax #):***	

Sendout Laboratory (Complete only if report needed)	**Other**
Laboratory & Contact Person	***Contact Name***
Address	***Address***
Phone Number	***Phone Number***
Email	***Email***
Test Reporting Instructions *Our preferred method of report transmission is email (via ShareFile)*	**Test Reporting Instructions** *Our preferred method of report transmission is email (via ShareFile)*
Email (via ShareFile): ☐ *use above*	***Email (via ShareFile):*** ☐ *use above*
☐ ***DO NOT email results. Instead, send via fax (provide fax #):***	☐ ***DO NOT email results. Instead, send via fax (provide fax #):***

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Billing Instructions

1. Please choose one of the three billing options:

- ☐ Institutional
- ☐ Individual
- ☐ Insurance

2. Provide all information for the selected option only

Note: Patient testing will be delayed until all of the billing requirements have been met. Please print clearly. If Individual/Insurance billing information is incomplete, the Institution will be billed. Tests that are cancelled while in progress will be billed for the amount of work completed up to that point. If the patient's specimen is collected in New York, a New York State Non-Permitted Laboratory Test Request approval letter must be included before testing will proceed.

1. Institutional Billing (Preferred)

Billing Institution		***PO Number***
Contact	***Phone Number(s)***	***Email***
Address		
City	***State***	***Zip***
Email Invoice **Email Address:**	***Copy of Test Report(s) for Billing*** ☐ **Email (via ShareFile):** ☐ same as previous ☐ **Other (please specify):**	

2. Individual Billing

Responsible Party's Name (Must be 18 years or older)	***Phone Number(s)***	***Email***
Address		
City	***State***	***Zip***

ACCEPTANCE OF FINANCIAL RESPONSIBILITY FOR GENETIC TESTING

Note: PreventionGenetics cannot proceed with testing of the specimen without a signature below.

My signature below indicates that I accept financial responsibility for all fees associated with this genetic testing order.

_____	_____	_____
Signature of Responsible Party	***Printed Name of Responsible Party***	***Date***

COMPLETE THE FOLLOWING FOR CREDIT CARD PAYMENT

Credit Card # / (VISA, Discover, or Mastercard only)	***Expiration Date***	***3-Digit Security Code***

My signature below authorizes PreventionGenetics to charge my credit card for services for which I am responsible.

Signature: ***Date:***

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Billing Instructions

3. Insurance Billing

We will file an insurance claim on behalf of the patient with any commercial insurance company. However, the claim will be submitted as an "out of network" service provider. We are in network (contracted provider) with a limited number of insurance plans (see website). The patient is responsible for any portion of the test fee not covered by the insurance company for any reason including, but not limited to, co-payments, co-insurance, unmet deductibles, or non-covered services.

Responsible Party's Name (Must be 18)	*Phone Number(s)*	*Email*

Responsible Party Address

City *State* *Zip*

Policyholder Name (Required)	*Please indicate the type of insurance: (Circle One)*	*Primary Insurance Company Name (Required)*
	Private / Medicare / WI Medicaid	

Insurance Company Address- Claims

City *State* *Zip*

ICD-10 Codes (Required)	*Policy ID#*	*Group #*	*Authorization #*

Please attach the following:

Note: PreventionGenetics cannot proceed with testing of the specimen until all information is received. There is a $100 DNA extraction fee if testing is not performed (does not apply if DNA is sent).

- ☐ *NPI # of Requesting Physician _____*
- ☐ *Medicare – signed ABN Form completed IN FULL*
- ☐ *Copy of both sides of Insurance Card*
- ☐ *Authorization number or letter of agreement from insurance company (if available). If not included, we will routinely perform pre-verification prior to initiating testing & will relay information to ordering provider.*
- ☐ *Letter of Medical Necessity*
- ☐ *Relevant Medical Records*
- ☐ *NY Non-permitted lab approval letter (if specimen collected in NY)*

AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR MY ACCOUNT

Note: PreventionGenetics cannot proceed with testing of the specimen without a signature below.

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.

_____ _____ _____

Signature of Patient or Guardian *Printed Name of Patient or Guardian* *Date*

Credit Card # / (VISA, Discover, or Mastercard only)	*Expiration Date*	*3- Digit Security Code*

My signature below authorizes PreventionGenetics to charge my credit card for services for which I am responsible upon completion of insurance processing.

Signature: Dr Geisl *Date:*

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Specimen Requirements

Below you will find our preferred specimen types by methodology and turnaround times (TAT). For prenatal testing, see our Prenatal Guidelines and contact us for details.

***STAT TAT (10 calendar days) available for 25% surcharge for Sanger sequencing. Cannot be guaranteed for aCGH.**

NextGen Sequencing (Maximum TAT: 45 days; Typical TAT: 3-4 weeks)

WHOLE BLOOD: Collect 3-5 ml of whole blood in EDTA (purple top tube) or ACD (yellow top tube), minimum 1 ml for small infants.

DNA: Send in screw cap tube at least 10 µg of purified DNA at a concentration of at least 50 µg/ml (indicate concentration on tube label).

SALIVA: Oragene™ Saliva Collection kit used according to manufacturer instructions.

CELL CULTURE & FRESH, FROZEN TISSUE: Please contact us for details.

Sanger Sequencing (Maximum TAT: 30 days; Typical TAT: 2-3 weeks)**

WHOLE BLOOD: Collect 3-5 ml of whole blood in EDTA (purple top tube) or ACD (yellow top tube), minimum 1 ml for small infants.

DNA: Send in screw cap tube at least 15 µg of purified DNA at a concentration of at least 20 µg/ml (indicate concentration on tube label). For tests involving the sequencing of more than three genes, send an additional 5 µg DNA per gene.

SALIVA: Oragene™ Saliva Collection kit used according to manufacturer instructions.

CELL CULTURE, SEMEN, & FRESH, FROZEN TISSUE: Please contact us for details.

Deletion/Duplication via aCGH (Maximum TAT: 30 days; Typical TAT: 3-4 weeks)**

WHOLE BLOOD: Collect 3-5 ml of whole blood in EDTA (purple top tube) or ACD (yellow top tube), minimum 1 ml for small infants.

DNA: Send in screw cap tube at least 1 µg of purified DNA at a concentration of at least 100 µg/ml (indicate concentration on tube label). We cannot accept DNA extracted from cultured cells.

FRESH, FROZEN TISSUE: Please contact us for details.

Whole-Genome Chromosomal Microarray (Maximum TAT: 21 days)

WHOLE BLOOD: Collect 3-5 ml of whole blood in EDTA (purple top tube), minimum 1-2 ml for small infants.

DNA: Collect at least 5 µg of DNA in TE (10 mM Tris-cl pH 8.0, 1mM EDTA), dissolved in 200 µl at a concentration of at least 100 ng/ul (indicate concentration on tube label). DNA extracted using a column-based method (Qiagen) or bead-based technology is preferred.

CELL CULTURE & FRESH, FROZEN TISSUE: Please contact us for details.

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Shipping Instructions & Additional Information

Shipping/Handling Instructions

Please label all specimen containers with the patient name, date of birth and/or ID number. At least two identifiers should be listed on specimen containers. We accept specimen deliveries Monday-Saturday for all specimen types except cell cultures. Cell culture deliveries are routinely accepted Monday-Thursday and require advance notice of arrival. If a Friday delivery is necessary please contact us to make arrangements. Holiday schedules will be posted on our home page at least one week prior to major holidays.

BLOOD: Do not freeze. During hot weather, include a frozen ice pack in the shipping container. Place a paper towel or other thin material between the ice pack and the blood tube. In cold weather include an unfrozen ice pack in the shipping container as insulation. At room temperature, blood specimen is stable for up to 48 hours. If refrigerated, blood specimen is stable for up to one week.

DNA: DNA may be shipped at room temperature. Label the tube with the composition of the solute, DNA concentration as well as the patient name, date of birth, and/or ID number. We only accept genomic DNA for testing. We do NOT accept products of whole genome amplification reactions or other amplification reactions.

CELL CULTURES: We are NOT able to culture cells. Send confluent flasks of cultured cells in insulated, shatterproof container overnight.

Address	Testing Kits
Diagnostic Lab PreventionGenetics 3800 S. Business Park Ave. Marshfield, WI 54449 USA	Clinical testing kits with prepaid return shipping are now available for our U.S. clients. We are able to provide Clinical Testing Kits to our international clients without the return postage at this time. To order kits, submit requests through our Electronic Order Form or contact our Client Service Representatives at 715-387-0484, ext. 0.

Prenatal Testing

Please sign Prenatal Healthcare Provider Statement and contact us in advance regarding prenatal test requests.

DNA Genotyping Panel

For quality control purposes, the PreventionGenetics DNA Genotyping Panel is performed on all clinical specimens. Genotyping results are ***not*** included in test reports.

DNA Banking

DNA Banking has a reduced price of $69 for patients if clinical testing is also being performed with us. For DNA Banking, see our DNA Banking Process and DNA Banking Forms. For questions related to DNA Banking, contact our DNA Banking Director at 715-387-0484, ext. 151 or email dnabanking@preventiongenetics.com.

Contact Us

For additional questions or concerns, please contact our Client Service Representatives at 715-387-0484, ext. 0 or our Genetic Counseling Team at ext. 208 or clinicaldnatesting@preventiongenetics.com.