PREVENTION GENETICS
DISEASE PREVENTION THROUGH GENETIC TESTING

3700 Downwind Drive
Marshfield, WI 54449
Phone: 715-387-0484
Fax: 715-384-3661

Test Requisition

(revised 2/21/2012)

Instructions

- **This form must accompany all specimens.**
- **Billing information is on the third page.**
- **Specimen and shipping instructions are listed on the fourth page.**
- **Test information is available from our web site (www.preventiongenetics.com)**

Patient Information

Patient's Last (Family) Name	*First Name*	*M.I.*	*Date of Birth:* ☐ *Month* ☐ *Day* ☐ *Year*
Requesting Institution's Patient ID Code	*Date Collected:* ☐ *Month* ☐ *Day* ☐ *Year*		*Gender* M ☐ F ☐
GeoAncestry/Ethnicity (Please provide as much information as possible.)			*ICD-9 code(s)*
Reason for test: Diagnosis ☐ Carrier Testing ☐ Presymptomatic Risk ☐ Confirmation of Known Mutation ☐			*Is this test related to an ongoing pregnancy?* Y ☐ N ☐
Has this patient or a family member been tested at PreventionGenetics previously?			*If so, when (approximately) and which test?*
Other relevant clinical information (Labs, biopsies, other genetic testing performed, etc.)			

Test Selection

Please list below the tests that are to be performed. The Test Numbers and Names can be obtained from our web site (www.preventiongenetics.com). Include any special Test instructions in the Comments section. The tests will be performed in the order listed unless otherwise specified.

Patient's Name (Last, First, MI)		
Test No.	*Test Name*	*Stat Option* ☐
Test No.	*Test Name*	*Stat Option* ☐
Test No.	*Test Name*	*Stat Option* ☐
Test No.	*Test Name*	*Stat Option* ☐

Comments

Turnaround times are < 40 calendar days after the specimen is received in nearly all cases. Exceptions include sequential testing of several large genes. We also offer a **STAT option** on our tests with ≤ 10 calendar day turnaround for an additional 25% of the list price.

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Physician / Laboratory Contact Information

Address For Report		Additional Report	
Requesting Physician / Genetic Counselor (please print legibly)		*Requesting Physician / Genetic Counselor (please print legibly)*	
Institution		*Institution (If same as on left, just mark 'Same".)*	
Address		*Address*	
City, State, Zip Code		*City, State, Zip Code*	
Phone Number	*Fax Only* ☐ *Mail Only* ☐ *Fax& Mail* ☐	*Phone Number*	*Fax Only* ☐ *Mail Only* ☐ *Fax& Mail* ☐
Fax Number	*Data CD* Y☐ N☐	*Fax Number*	*Data CD* Y☐ N☐
Email Address		*Email Address*	

Additional Report		Additional Report	
Requesting Physician / Genetic Counselor (please print legibly)		*Requesting Physician / Genetic Counselor (please print legibly)*	
Institution		*Institution (If same as on left, just mark 'Same".)*	
Address		*Address*	
City, State, Zip Code		*City, State, Zip Code*	
Phone Number	*Fax Only* ☐ *Mail Only* ☐ *Fax& Mail* ☐	*Phone Number*	*Fax Only* ☐ *Mail Only* ☐ *Fax& Mail* ☐
Fax Number	*Data CD* Y☐ N☐	*Fax Number*	*Data CD* Y☐ N☐
Email Address		*Email Address*	

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Billing Information

Please choose an option.

Note: Patient testing will be delayed until all 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.

Institutional Billing (Preferred)

Billing Institution ***PO Number***

Contact ***Phone Number(s) / Email (Required)***

Address (include city/state/zip) ***Fax Number***

Email Invoice: Yes ☐ No ☐

Copy of Test Report for Billing: Yes ☐ No ☐

Individual Billing (This section required for individual and/or insurance billing)

Responsible Party's Name (Must be 18 years or older)

Address (include city/state/zip)

Phone Number(s) / Email (Required)

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

Insurance Billing

We DO NOT accept any Medicaid or Medicare. We do not participate with any insurance company plan at this time. We will be submitting claims as an "out of network" service provider and will courtesy bill the insurance company. It is the responsibility of the patient to contact the insurance company regarding prior authorization, claim status and/or payment disputes. The patient is responsible for the balance of fees not covered by insurance. We do not accept insurance payment rates as payment in full.

The following information must be submitted to bill the insurance company:

- The 'individual' section above must be completed.
- Copy of both sides of the insurance card (must be readable)
- An authorization number or letter of agreement from the insurance company, if available.
- We will charge the individual's credit card 45 days from date of claim submission for balance due or for payment in full.
- Do you wish to be notified when we charge your credit card? Y / N

Policyholder Name _____ Primary Insurance Carrier _____

Policy ID#: _____Group No. _____ Authorization #: _____ ICD-9 Code(s): _____

Claims Mailing Address: (required) _____

_____

AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR MY ACCOUNT

Note: PreventionGenetics cannot proceed with testing of the specimen on insurance bill cases without a signature below.

I assign and authorize insurance payments to PreventionGenetics. I understand my insurance 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 responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State and Federal law.

_____ _____ _____

Signature of Patient or Guardian (Required) Printed name of Patient or Guardian (Required) Date (Required)

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Specimen Requirements and Shipping Instructions

Blood Specimen Requirements:

(Delivery accepted Monday – Saturday)

- Collect 2-5 ml (5 ml preferred) of whole blood in EDTA (purple top tube) or ACD (yellow top tube). For Test #500-DNA Banking only, collect 10-20 ml of whole blood.
- **For small babies, we require a minimum of 1 ml of blood.**
- Only one blood tube is required for multiple tests.
- Ship blood tubes at room temperature in an insulated container. **Do not freeze blood.**
- 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 good for up to 48 hours.
- If refrigerated, blood specimen is good for up to one week.
- Label the tube with the patient name, date of birth and/or ID number.

DNA Requirements:

(Delivery accepted Monday – Saturday)

- Send in a screw cap tube at least 15 µg of **purified** DNA at a concentration of at least 20 µg/ml. For tests involving the sequencing of more than three genes, send an additional 5 µg DNA per gene. DNA may be shipped at room temperature.
- **Label the tube with the DNA concentration as well as the patient name, date of birth, and/or ID number.**
- Specify the composition of the solute.
- **We only accept genomic DNA for testing.** We do **not** accept products of whole genome amplification reactions or other amplification reactions.

DNA Genotyping Panel:

For quality control purposes, the PreventionGenetics DNA Genotyping Panel (Test #490) is performed on all clinical specimens. Unless specifically requested, genotyping results are ***not*** included in the test reports.

Cell Culture Requirements:

(Delivery accepted Monday – Thursday)

- **PreventionGenetics should be notified in advance of arrival of a cell culture.**
- Ship at least two T25 flasks of confluent cells.
- **Label the flasks with the patient name, date of birth, and/or ID number.**
- We do not culture cells.

Shipping Instructions:

Ship all specimens to:

Diagnostics Lab
PreventionGenetics
3700 Downwind Drive
Marshfield, WI 54449
USA

You are responsible for shipping costs.