Constitutional Cytogenetics Requisition (non-cancer)

2110 Research Row, Suite 221
Dallas, Texas 75235
PHONE: 214-645-7057
Toll Free: 877-887-8136
FAX: 214-645-7035
CLIA #45D-0659587, CAP #2723201

VERIPATH LABORATORIES
www.veripathlabs.com

ACCOUNT INFORMATION

Client Name/Account Number:

Client Address:

City/State/Zip:

Client Phone: | Client FAX:

REQUIRED ORDER INFORMATION

BILL TO: ☐ Facility / Client ☐ Patient / 3rd party **– Billing information must be provided**

Patient Name: (Last, First, Middle)

Mother's Name: (if infant)

Date of Birth: | Sex: | Patient ID / MR#:

Hospital Inpatient Y / N | Collection Date: | Collection Time: : AM PM

Ordering Physician: | NPI:

Phone: | Pager: | FAX:

Clinical Indication for Tests Ordered:

SPECIMEN INFORMATION

☐Blood [C/CYTO OTH]

☐Amniotic fluid [C/CYTO AMN]

☐CVS [C/CYTO CVS]

☐PUBS [C/CYTOPUBS]

☐Products of conception [C/CYTO OTH]

☐Tissue: site/type ____________________ [C/CYTO OTH]

☐ Other: ____________________ [C/CYTO OTH]

PREGNANT PATIENTS:

LMP ____________

Gest age by ultrasound: ____wks ____days

PATIENT/3RD PARTY BILLING INFORMATION

ICD-9 Code(s)

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) on reverse side. ☐Signed ABN included

ICD-9 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

Insured/Responsible Party Name: (if different from patient-Last, First, Middle) | Date of Birth:

Patient's relationship: ☐Self ☐Spouse ☐Dependent ☐Other | Responsible Party Address: (street, city, State, zip)

Sex: | Phone:

Employer's Name: | Employer's Phone:

Insurance Co. Name: | Insurance Co. Phone:

Insurance Co. Address:

Policy #: | Group #:

☐Medicare ☐HMO ☐Other ☐Medicaid ☐PPO | Member ID#:

Referral Authorization/Precertification #:

Name: Date/Time:

DIAGNOSTIC INFORMATION

PRENATAL:

☐Advanced maternal age
☐Serum screen positive for:
___ Down syndrome
___ NTD (increased MSAFP)
___ Trisomy 18
___ Other:____________
☐Abnormal fetal sonogram
____
☐Other:____________

POSTNATAL - suspected diagnosis:

☐Down syndrome
☐Trisomy 13
☐Trisomy 18
☐Turner syndrome*
☐Other ____________

*Mosaicism screen (additional cell counts) will be performed at an additional charge when routine study is normal for suspected Turner syndrome.

Check at least one symptom:

☐Ambiguous genitalia
☐Congenital anomalies
____
____
☐Developmental delay
☐Fetal demise/miscarriage
☐Infertility
☐Multiple miscarriages
☐Short stature
☐Family history of chromosomal anomaly
____
☐Family history of congenital anomaly
____
☐Other:____________

TEST REQUESTED

☐Chromosomal analysis

☐Chromosomal analysis with FISH **(SPECIFY FISH)**

☐FISH only **(SPECIFY FISH)** (provide prior chromosome results)

☐Amniotic fluid AFP
(AChE will be performed at an additional charge when AFAFP is positive.)

☐Amniotic fluid acetyl cholinesterase (AChE)

☐Fibroblast culture - specify test to be performed and the referral lab:
____
____

FISH TESTS

Aneuploidy: ☐13 ☐18 ☐21 ☐X/Y
☐Aneuploidy Panel (13, 18, 21, X/Y)

Telomere panel ☐ Chromosomal subtelomeric sequences

Microdeletion Syndromes:

☐Angelman
☐Cri du chat (5p-)
☐Deletion 1p36
☐DiGeorge/velo-cardio-facial (22q11.2 deletion)
☐Miller-Dieker
☐Prader-Willi
☐Smith-Magenis
☐Williams
☐Wolf-Hirschhorn (4p-)
☐Other: (call lab)
____

REPORTING: Please specify where additional report should be sent

Name:____________ Address:____________

FAX:____________ City/State/Zip:____________

VERIPATH USE ONLY

Transport Container: **Total # of specimens:**____
___Yellow ___Green ___Purple ___Syringe ___Conical ___Red ___Blue ___Cup
___Trans Tube ___Block ___Slides ___Formalin ___Other:____

Transport Conditions: ☐Frozen ☐Slushy ☐Refrig ☐Room Temp

Destination: ☐Other____ ☐Aston ☐Coag ☐Cytogen ☐Flow ☐Hist ☐Mol Dx ☐OncoDx

Initials:

(A) Notifier(s):
(B) Patient Name: **(C) Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for ***(D)***_____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the ***(D)***_____________ below.

(D)_______________	***(E)*** **Reason Medicare May Not Pay:**	***(F)*** **Estimated Cost:**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the ***(D)***_____________listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) **OPTIONS:** **Check only one box. We cannot choose a box for you.**
❑ **OPTION 1.** I want the ***(D)***__________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
❑ **OPTION 2.** I want the ***(D)***__________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.
❑ **OPTION 3.** I don't want the ***(D)***__________listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) **Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) **Signature:**	***(J)*** **Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.