MicroGen Health

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PLEASE SUBMIT THE FOLLOWING WITH REQUISITION FORM

1. Clinical Notes 2. Pedigree 3. Insurance

DIABETES REQUISITION FORM

COMPLETE ENTIRE FORM AND SUBMIT PEDIGREE/CLINIC NOTES TO AVOID DELAYS

PATIENT INFORMATION

Last Name	First Name		
Date of Birth (MM/DD/YYYY)	Gender ○ Male ○ Female ○ Unknown		
Med Rec#/Patient Identifier	Ethnicity		
Address			
City	State/Province	Zip Code	Country
Phone	Email		

Sample Collection Date (MM/DD/YYYY)

Sample Type ○ Blood ○ Buccal ○ Other

FAMILY HISTORY

Attach pedigree and additional pages as needed

Name (Person 1)	Relation to Patient	Gender ○ Male ○ Female ○ Unknown	
Diagnosis and/or Symptoms		Age	DOB (MM/DD/YYYY)
Name (Person 2)	Relation to Patient	Gender ○ Male ○ Female ○ Unknown	
Diagnosis and/or Symptoms		Age	DOB (MM/DD/YYYY)
Name (Person 3)	Relation to Patient	Gender ○ Male ○ Female ○ Unknown	
Diagnosis and/or Symptoms		Age	DOB (MM/DD/YYYY)

ORDER PROVIDER

Institution/Practice Name	Institution Phone/Fax/Email		
Provider Last Name	Provider First Name		
NPI	Provider Title		
Provider Address			
City	State/Province	Zip Code	Country
Provider Phone	Fax Report to	Primary Contact	Primary Contact Phone/Email/Fax

ICD 10 Codes

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

TEST REQUESTED ☐ CHECK ALL

TEST NAME: DIABETES TEST PANEL

☐ ABCC8	☐ BBS12	☐ CEL	☐ GNAS	☐ MAGEL2	☐ PDX1	☐ SDCCAG8
☐ ADRB2	☐ BBS2	☐ CEP290	☐ HNF1A	☐ MC4R	☐ POMC	☐ SIM1
☐ ADRB3	☐ BBS4	☐ EIF2AK3	☐ HNF1B	☐ MKKS	☐ PPARG	☐ TRIM32
☐ AGRP	☐ BBS5	☐ ENPP1	☐ HNF4A	☐ MKS1	☐ PPARGC1B	☐ TTC8
☐ ALMS1	☐ BBS7	☐ FOXP3	☐ INS	☐ NEUROD1	☐ PTF1A	☐ UCP1
☐ ARL6	☐ BBS9	☐ GCK	☐ KCNJ11	☐ NEUROG3	☐ PYY	☐ UCP3
☐ BBS1	☐ BDNF	☐ GHRL	☐ LEP	☐ NTRK2	☐ RFX6	☐ WDPCP
☐ BBS10	☐ CARTPT	☐ GLIS3	☐ LEPR	☐ PCSK1	☐ SDC3	☐ WFS 1

TEST SPECIFICS

Ex: DUO/TRIO (needs additional information/consent for testing), known mutation(s), hold samples, and so on...

☐ For clinical or whole-exome sequencing: If you want to receive ACMG secondary findings, check this box. If this box is checked, a signed Informed Consent Form must be submitted.

TEST OPTIONS

Omitted test options will default to Seq & Del/Dup. Additional charges may apply.

○ Sequencing Only ○ Seq & Del/Dup
○ Del/Dup Only

ORDER OPTIONS

Additional charges may apply.

☐ Prenatal ☐ MCC
☐ Exclude VUS ☐ Rush/STAT

REFLEX OPTIONS

Reflex options may not be available for all tests. Additional charges will apply.

○ All-in-One (Extended) ○ Whole-in-One

INDICATIONS FOR TESTING

Check all that apply.

☐ Diagnostic ☐ Family History
☐ Presymptomatic ☐ Other:
☐ Family Variant

CLINICAL/SUSPECTED DIAGNOSIS: Please attach medical records

The lab may perform confirmation of parental relationships for quality control or other purposes. ☐ Check here to opt-out.

INSURANCE BILLING

Please Attach Insurance Cards for Billing

Referral / Prior Auth

Primary Member ID / Policy ID	Insurance Name	State	Group No	Insurance Phone #
Insurance Plan	Name of Insured		Relation to Patient	Date of Birth (MM/DD/YYYY)
Secondary Member ID / Policy ID	Insurance Name	State	Group No	Insurance Phone #
Insurance Plan	Name of Insured		Relation to Patient	Date of Birth (MM/DD/YYYY)

DIABETES REQUISITION FORM

INSTITUTIONAL BILLING

Institution / Practice Name			
Attention to			
Address			
City	State / Province	Zip Code	Country
Phone	Fax / Email		

SELF PAY

○ Use patient information above for billing ○ Use information below for billing

Payor Last Name	Payor First Name		
Address			
City	State / Province	Zip Code	Country
Phone	Fax / Email		

REQUIRED FOR INSURANCE CHECKLIST

- ☐ Copy of insurance card(s) - front/back
- ☐ Insurance authorization, if available
- ☐ Detailed medical record (pedigree if available)
- ☐ Insurer specific forms (i.e. ABN)
- ☐ For medicare, medicare criteria form is required
- ☐ Physician, patient, and insured signatures

STOP PATIENT SIGNATURE

I hereby assign all rights and benefits under my health plan and all rights and obligations that I and my dependents have under my health plan to MicroGen Health its assigned affiliates and authorized representatives for laboratory services furnished to me by MicroGen Health. I irrevocably designate, authorize and appoint MicroGen Health or its assigned affiliates and their authorized representatives as my true and lawful attorney-in-fact for the purpose of submitting my claims, obtain a copy of my health plan document, summary plan description, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with federal or state laws. If my health plan fails to abide by my authorization and makes payment directly to me, I agree to endorse the insurance check and forward it to MicroGen Health immediately upon receipt. I hereby authorize MicroGen Health its assigned affiliates and authorized representatives to contact me or my health Plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that I have provided to MicroGen Health, in compliance with federal and state laws. MicroGen Health, its assigned affiliates and their authorized representatives may release to my health plan administrator, my employer, and my authorized representative my personal health information for the purpose of procuring payment of MicroGen Health and for all the laboratory services. I understand the acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance.

Signature of Patient or Patient Representative / Relationship to Patient **Date:**

Parent/Guardian signature **Date:**

☐ **By Checking this box, the ordering provider certifies that the patient cannot physically Sign the Release and Consent**

TO BE FILLED IN BY PHYSICIAN

CLINICAL HISTORY

DETAILS

Check all that apply:

- ☐ Bone Marrow Transplant
- ☐ Organ Transplant
- ☐ Consanguinity
- ☐ Mosaicism
- ☐ Known Gene Gain/Loss
- ☐ Known Chromosomal Gain/Loss

Many factors can influence genetic diagnostic tests, like gene-gene interactions, transplants and so on. Please list any that may be applicable.

FINDINGS

Please list any findings that may be related to genetic testing.

- Physical
- Phenotypes
- Behavior
- Conditions
- Symptoms
- Pedigree/Family History

There are many symptoms that do not appear to be directly related to disease. Please list the most likely diagnoses and provide extensive medical documents and/or pedigrees.

TESTING

Please indicate any clinical testing results and/or findings that may be relevant to genetic testing:

- Vision
- Biochemical Testing
- Previous Genetic Testing
- Hearing
- Imaging
- Pathology Reports
- Karyotype
- Growth Measurements

Please add tests that with negative results as well to assist our clinical staff in interpreting the findings of your examination.

STOP ORDERING PHYSICIAN SIGN HERE

I attest that the patient has received and read the MicroGen Health Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any MicroGen Health Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY
By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

Physician's Signature (Required) Date (MM/DD/YYYY)