MicroGen HEALTH
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PLEASE SUBMIT THE FOLLOWING WITH REQUISITION FORM

1. Clinical Notes 2. Pedigree 3. Insurance

PLEASE ATTACH DETAILED MEDICAL RECORDS, INSURANCE CARD FRONT/BACK, AND CLINICAL INFORMATION TO THE REQUISITION FORM.

CGx REQUISITION FORM

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

PATIENT INFORMATION*

*First Name | Middle Name

*Last Name

*Date of Birth: MM / DD / YYYY | *Phone Number

*Email

*Address

*City | *State | *Zip

*Gender: ○ Male ○ Female ○ Others

Ethnicity: ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Ashkenazi Jewish ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ Other

OTHER PERSONAL INFORMATION

☐ Ashkenazi Jewish descent ☐ Previous genetic testing for hereditary cancer
☐ Bone marrow transplant recipient ☐ Current diagnosis of a hematologic cancer

SPECIMEN INFORMATION*

☐ Buccal Swab ☐ Blood ☐ Tissue | Medical Record#

*Collection Date | *Collected By | Specimen ID

☐ Specimen is post - mortem Date of Death: MM / DD / YYYY

PATIENT'S PERSONAL HISTORY*

Cancer / tumor	Personal history	Age at Dx
Breast ☐ Triple negative (ER-, PR-, HER2-) ☐ Multiple primaries	○ Yes ○ No	
Ovarian ☐ Check if non-epithelial	○ Yes ○ No	
Prostate (Gleason score ≥ 7)	○ Yes ○ No	
Pancreatic	○ Yes ○ No	
Endometrial/Uterine	○ Yes ○ No	
Colon/Rectal	○ Yes ○ No	
Stomach	○ Yes ○ No	
Melanoma	○ Yes ○ No	
Other cancer(s):		

FAMILY HISTORY OF CANCER

Relationship	Maternal or Paternal	Cancer site(s)	Age at Dx
	○ ○		
	○ ○		
	○ ○		

☐ **OPTION 1: INSURANCE BILLING** (Include copy of both sides of insurance card)*

Patient Relation to Policy Holder? ☐ Self ☐ Spouse ☐ Child

Name and DOB of Policy Holder (If not self) .....

Insurance Company | Policy# | HMO Auto#

Out of Pocket: We will start testing immediately unless you check the box below. We will attempt to contact you if estimated out-of-Pocket costs are > USD $100.

☐ Do not start testing until I approve payment terms regarding estimated out-of-pocket costs Patient agrees to contact regarding out-of-pocket amount by:

☐ Email ☐ Phone(includes tests) - confirm mobile # .....

☐ **INSTITUTIONAL BILLING*** ☐ **SELF-PAY**

*Facility Name ☐ Send Invoice to facility Address above

*Address

*Contact Name

*Phone Number

*E-mail Fax

☐ PATIENT PAYMENT ☐ Check (Payable To) ☐ Credit Card

Special Billing Notes:

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.

I have read the Informed Consent document and I give permission to MicroGen Health to perform genetic testing as described.
If you are a New York state resident and give permission for MicroGen Health to retain any remaining sample longer than 60 days after the completion of testing.
By signing above, the patient or payor authorizes MicroGen Health to contact them directly, and use the provided billing instructions to bill the indicated method.

*Patient Signature | *Date: MM / DD / YYYY

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

*Parent/Guardian signature | *Name: | *Date: MM / DD / YYYY

CGx REQUISITION FORM

ICD-10 REFERENCE SHEET (Hereditary Cancer)

BREAST CANCER

- ☐ C50.019 Malignant neoplasm of nipple and areola unspecified female breast
- ☐ C50.119 Malignant neoplasm of central portion of unspecified female breast
- ☐ C50.219 Malignant neoplasm of upper-inner quadrant of unspecified female breast
- ☐ C50.319 Malignant neoplasm of lower-inner quadrant of unspecified female breast
- ☐ C50.419 Malignant neoplasm of upper-outer quadrant of unspecified female breast
- ☐ C50.519 Malignant neoplasm of lower-outer quadrant of unspecified female breast
- ☐ C50.619 Malignant neoplasm of axillary tail of unspecified female breast
- ☐ C50.819 Malignant neoplasm of overlapping sites of unspecified female breast
- ☐ C50.919 Malignant neoplasm of unspecified site of unspecified female breast
- ☐ C79.81 Secondary malignant neoplasm of unspecified breast
- ☐ D05.00 Lobular carcinoma in situ of unspecified breast
- ☐ D05.01 Lobular carcinoma in situ of right breast
- ☐ D05.02 Lobular carcinoma in situ of left breast
- ☐ D05.90 Unspecified type of carcinoma in situ of unspecified breast
- ☐ D05.91 Unspecified type of carcinoma in situ of right breast
- ☐ D05.92 Unspecified type of carcinoma in situ of left breast
- ☐ Z15.01 Genetic susceptibility to malignant neoplasm of breast
- ☐ Z80.3 Family history of malignant neoplasm of breast
- ☐ Z85.3 Personal history of malignant neoplasm of breast

MALE BREAST CANCER

- ☐ C50.029 Malignant neoplasm of nipple and areola, unspecified male breast
- ☐ C50.129 Malignant neoplasm of central portion of unspecified male breast
- ☐ C50.229 Malignant neoplasm of upper-inner quadrant of unspecified male breast
- ☐ C50.329 Malignant neoplasm of lower-inner quadrant of unspecified male breast
- ☐ C50.429 Malignant neoplasm of upper-outer quadrant of unspecified male breast
- ☐ C50.529 Malignant neoplasm of lower-outer quadrant of unspecified male breast
- ☐ C50.629 Malignant neoplasm of axillary tail of unspecified male breast
- ☐ C50.829 Malignant neoplasm of overlapping sites of unspecified male breast
- ☐ C50.929 Malignant neoplasm of unspecified site of unspecified male breast

PROSTATE CANCER

- ☐ C61 Malignant neoplasm of prostate
- ☐ D07.5 Carcinoma in situ of prostate
- ☐ Z15.03 Genetic susceptibility to malignant neoplasm of prostate
- ☐ Z80.42 Family history of malignant neoplasm of prostate
- ☐ Z85.46 Personal history of malignant neoplasm of prostate

STOMACH CANCER

- ☐ C16.8 Malignant neoplasm of overlapping sites of stomach
- ☐ C16.9 Malignant neoplasm of stomach, unspecified
- ☐ Z85.028 Personal history of malignant neoplasm of stomach

COLON CANCER / ADENOMAS

- ☐ C18.2 Malignant neoplasm of ascending colon
- ☐ C18.4 Malignant neoplasm of transverse colon
- ☐ C18.6 Malignant neoplasm of descending colon
- ☐ C18.7 Malignant neoplasm of sigmoid colon
- ☐ C18.9 Malignant neoplasm of colon, unspecified
- ☐ C7A.022 Malignant carcinoid tumor of the ascending colon
- ☐ C7A.023 Malignant carcinoid tumor of the transverse colon
- ☐ C7A.024 Malignant carcinoid tumor of the descending colon
- ☐ C7A.025 Malignant carcinoid tumor of the sigmoid colon
- ☐ Z83.71 Family history of colonic polyps
- ☐ Z86.010 Personal history of colonic polyps

OVARIAN CANCER

- ☐ C56.9 Malignant neoplasm of unspecified ovary
- ☐ C79.60 Secondary malignant neoplasm of ovary
- ☐ C79.61 Secondary malignant neoplasm of right ovary
- ☐ C79.62 Secondary malignant neoplasm of left ovary
- ☐ Z15.02 Genetic susceptibility to malignant neoplasm of ovary
- ☐ Z40.02 Encounter for prophylactic removal of ovary
- ☐ Z80.41 Family history of malignant neoplasm of ovary
- ☐ Z85.43 Personal history of malignant neoplasm of ovary

PANCREATIC CANCER

- ☐ C25.0 Malignant neoplasm of head of pancreas
- ☐ C25.1 Malignant neoplasm of body of pancreas
- ☐ C25.2 Malignant neoplasm of tail of pancreas
- ☐ C25.7 Malignant neoplasm of other parts of pancreas
- ☐ C25.8 Malignant neoplasm of overlapping sites of pancreas
- ☐ C25.9 Malignant neoplasm of pancreas, unspecified
- ☐ Z80.0 Family history of neoplasm of digestive organs
- ☐ Z85.07 Personal history of malignant neoplasm of pancreas

UTERINE (ENDOMETRIAL) CANCER

- ☐ C57.4 Malignant neoplasm of uterine adnexa, unspecified
- ☐ N85.02 Endometrial intraepithelial neoplasia [EIN]
- ☐ Z80.49 Family history of malignant neoplasm of other genital organs
- ☐ Z85.42 Personal history of malignant neoplasm of other parts of uterus

OTHER CANCER

- ☐ D07.39 Carcinoma in situ of other female genital organs
- ☐ Z31.430 Encounter of female for testing for genetic disease carrier status for procreative management
- ☐ Z31.440 Encounter of male for testing for genetic disease carrier status for procreative management
- ☐ Z80.8 Family history of malignant neoplasm of other organs or systems
- ☐ Z80.9 Family history of malignant neoplasm, unspecified
- ☐ Z84.81 Family history of carrier of genetic disease

MELANOMA

- ☐ C43 Malignant melanoma of skin
- ☐ C43.0 Malignant melanoma of lip
- ☐ C43.1 Malignant melanoma of eyelid, including canthus
- ☐ C43.10 Malignant melanoma of unspecified eyelid, including canthus
- ☐ C43.11 Malignant melanoma of right eyelid, including canthus
- ☐ C43.12 Malignant melanoma of left eyelid, including canthus
- ☐ C43.2 Malignant melanoma of ear and external auricular canal
- ☐ C43.20 Malignant melanoma of unspecified ear and external auricular canal
- ☐ C43.21 Malignant melanoma of right ear and external auricular canal
- ☐ C43.22 Malignant melanoma of left ear and external auricular canal
- ☐ C43.3 Malignant melanoma of other and unspecified parts of face
- ☐ C43.30 Malignant melanoma of unspecified part of face
- ☐ C43.31 Malignant melanoma of nose
- ☐ C43.39 Malignant melanoma of other parts of face
- ☐ C43.4 Malignant melanoma of scalp and neck
- ☐ C43.5 Malignant melanoma of trunk
- ☐ C43.51 Malignant melanoma of anal skin
- ☐ C43.52 Malignant melanoma of skin of breast
- ☐ C43.59 Malignant melanoma of other part of trunk
- ☐ C43.6 Malignant melanoma of upper limb, including shoulder
- ☐ C43.60 Malignant melanoma of unspecified upper limb, including shoulder
- ☐ C43.61 Malignant melanoma of right upper limb, including shoulder
- ☐ C43.62 Malignant melanoma of left upper limb, including shoulder
- ☐ C43.7 Malignant melanoma of lower limb, including hip
- ☐ C43.70 Malignant melanoma of unspecified lower limb, including hip
- ☐ C43.71 Malignant melanoma of right lower limb, including hip
- ☐ C43.72 Malignant melanoma of left lower limb, including hip
- ☐ C43.8 Malignant melanoma of overlapping sites of skin
- ☐ C43.9 Malignant melanoma of skin, unspecified

The diagnosis codes provided on this form do not represent an exclusive list of appropriate ICD-10 codes. Our company does not intend to imply that these codes should be used. The provider is responsible for determining the medical necessity of laboratory tests and for assigning and providing the specific ICD-10 code(s) to support the medical necessity of clinical laboratory test(s).

CGx REQUISITION FORM

TO BE FILLED IN BY PHYSICIAN

*ORDERING PHYSICIAN/SENDING FACILITY (Each Listed person will receive a copy of the report)

*Facility Name (Facility Code):

*Client: *Address: *City:

*Phone: *State/Country: *Zip:

*Ordering Licensed Provider	*First Name	*Last Name	*Code	*NPI	*Fax/Phone

Additional Results Recipients

Genetic Counselor or Other Medical Provider	First Name	Last Name	Phone/Fax/Email

*ICD-10 Codes

GENETIC COUNSELING ☐
In the case of a positive result, patient does not require genetic counseling by a board-certified genetic counselor at MicroGen Health.

VUS DETAILS
In the event a Variant of Uncertain Significance (VUS) is identified, you and your patient will receive the technical details in the report

INFORMED CONSENT ☐
Patient must consent

PATIENT RESULTS
MicroGen Health will automatically release results to your patient after 20 days. If you would like your patient to view their results earlier, you can manually release the results.

MEDICAL NECESSITY ☐
Required for insurance
I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder, and that the results will be used in medical management and care decisions for the patient.

I attest that the patient has read the MicroGen Health Informed Consent or had it read to him or her, and that I have fully informed the patient about the purpose, capabilities and limitations of MicroGen Health Hereditary Cancer Test. The patient has voluntarily given full consent for MicroGen Health Hereditary Cancer 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.

CANCER GENOMICS (CGx) PANEL

Cancer genomics panel covers 25 genes

- ☐ **Breast cancer (6 Genes)** — BARD1, BRCA1, BRCA2, BRIP1, RAD51C, RAD51D.
- ☐ **Colorectal cancer (5 Genes)** — EPCAM, MSH6, PMS2, POLD1, POLE.
- ☐ **Ovarian cancer (4 Genes)** — BRCA1, BRCA2, RAD51C, RAD51D.
- ☐ **Pancreatic cancer (3 Genes)** — CDKN2A (p14ARF), CDKN2A (p16INK4a), PALB2.
- ☐ **Gastric cancer (2 Genes)** — CDH1, MUTYH.
- ☐ **Prostate cancer (1 Gene)** — CHEK2.
- ☐ **Melanoma, malignant, cutaneous (2 Genes)** — CDK4, MITF.
- ☐ **Telangiectasia (2 Genes)** — ATM, SMAD4.

COMPREHENSIVE CANCER GENOMICS PANEL GENES ☐

BARD1, BRCA1, BRCA2, BRIP1, RAD51C, RAD51D, EPCAM, MSH6, PMS2, POLD1, POLE, BARD1, BRCA1, BRCA2, RAD51C, RAD51D, CDKN2A (p14ARF), CDKN2A (p16INK4a), PALB2, CDH1, MUTYH, CHEK2, CDK4, MITF, ATM, SMAD4.

STOP ORDERING PHYSICIAN CONSENT (SIGNATURE)

CONFIRMATION OF INFORMED CONSENT, PRE-TEST GENETIC COUNSELING, AND MEDICAL NECESSITY FOR GENETIC TESTING

The undersigned person (or representative thereof) ensures he/she is a licensed medical professional authorized to order genetic testing and confirms that the patient has given appropriate consent. I confirm that testing is medically necessary and the test results may impact medical management for the patient. I agree to allow..... To facilitate the provision of pre-test genetic counseling services by a third party service, informed DNA (unless otherwise noted ☐), as required by the patient's insurance provider (unless this box is checked ☐) Furthermore, all information on this Requisition Form is true to the best of my knowledge. My signature applies to the attachment letter of medical necessity.

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.

*Medical Professional Signature	*Name:	*Date: MM / DD / YYYY
*Ordering Physician Signature		*Date: MM / DD / YYYY

CGx REQUISITION FORM

INSTRUCTIONS:

1. Complete the patient and provider information section.
2. Read and sign the informed consent policy statement by the patient. Signature from the patient is required for billing and Test Authorization purposes.
3. Signature from the provider on Page 1 of the TRF is required for all testing.
4. Write in the test name on Page 1 or select the gene(s)/panel(s) below.
5. Indicate any relevant test options on Page 1.
6. Please visit www.microgenhealth.com for specimen requirements.

REQUIRED FOR INSURANCE CHECKLIST

1. Detailed medical record (pedigree if available)
2. ICD-10 code(s)
3. Physician, patient, and insured signatures
4. Medical Necessity Letter, Patient Informed Consent Document
5. Copy of insurance card(s) - front / back
6. Insurer specific forms (i.E. ABN)
7. Insurance authorization, if available
8. For medicare, medicare criteria form is required

PAGE 4 OF 4