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.

CARDIOVASCULAR GENOMICS TEST 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

SPECIMEN INFORMATION* (For Phlebotomist service, select all services you are requesting)

☐ Buccal Swab | Medical Record#

*Collection Date | *Collected By | Specimen ID

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

FAMILY HISTORY*

☐ None (Maternal) ☐ None (Paternal) ☐ Maternal hx unknown ☐ Paternal hx unknown

*Completing this section is not mandatory for ordering, but recommended and helps with claims filing. Pedigree and other clinical family history notes should be supplied as well when sending in your order.

Relation to Patient	Mat	Pat	H/o cardio disease	Dx age
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

CLINICAL HISTORY (PLEASE SUPPLY CLINIC NOTES AND PEDIGREE)

☐ No personal history of cardiovascular disease

Sudden Cardiac arrest ☐Y ☐N (if yes): # Episodes:.....Age first incident:.....

Syncope ☐Y ☐N (if yes): Episodes:.....Age first incident:.....

History of Cardiovascular ☐Y ☐N Age at dx:.....

Type(s) of Cardiovascular:.....

History of Arrhythmia ☐ Y ☐ N Age at dx:.....

☐ Types (s) of Arrhythmia:.....

☐ Clinical diagnosis of Marfan Syndrome or other connective tissue disorder

☐ Aortic Aneurysm/Dilation Age at dz:..... z-score:.....

☐ Other Aneurysm Location:..... Age at dz:.....

☐ Aortic/Vascular Dissection Location:..... Age at dz:.....

☐ History of Familial hypercholesterolemia

☐ Other history:.....

☐ *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 # .....

Special Billing Notes:

☐ 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

STOP PATIENT CONSENT (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

CARDIOVASCULAR TEST REQUISITION FORM

ICD-10 DIAGNOSIS CODES WITH DESCRIPTION

- ☐ E78.4 - Other Hyperlipidemia
- ☐ E78.5 - Hyperlipidemia, unspecified
- ☐ E87.1 - Hypo - osmolality and / or hypernatremia
- ☐ G89.29 - Other Chronic Pain
- ☐ 110 - Essential (Primary) Hypertension
- ☐ 10 - Essential (Primary) Hypertension
- ☐ 125.10 - Atherosclerotic heart disease of native coronary artery without angina pectoris
- ☐ 125.5 - Ischemic Cardiovascular
- ☐ 125.6 - Silent Myocardial Ischemia
- ☐ 125.89 - Other forms of chronic ischemic heart disease
- ☐ 125.9 - Chronic ischemic heart disease, unspecified
- ☐ 134.1 - Nonrheumatic mitral (valve) insufficiency
- ☐ 134.1 - Nonrheumatic mitral (valve) prolapse
- ☐ 134.2 - Nonrheumatic mitral (valve) stenosis
- ☐ 135.8 - Other nonrheumatic mitral valve disorders
- ☐ 134.9 - Nonrheumatic mitral valve disorder, unspecified
- ☐ 135.0 - Nonrheumatic aortic (Valve) stenosis
- ☐ 135.1 - Nonrheumatic aortic (Valve) Insufficiency
- ☐ 135.2 - Nonrheumatic aortic (valve) stenosis with insufficiency
- ☐ 135.8 - Other Nonrheumatic aortic (valve) disorders
- ☐ 135.9 - Nonrheumatic aortic valve disorder, unspecified
- ☐ 142.0 - dilated Cardiovascular
- ☐ 142.5 - Other restrictive Cardiovascular
- ☐ 142.9 - Supraventricular tachycardia
- ☐ 149.2 - Junctional premature depolarization
- ☐ 148.0 - Paroxysmal atrial fibrillation
- ☐ 148.2 - Chronic atrial fibrillation
- ☐ 149.91 - Unspecified atrial fibrillation
- ☐ 149.8 - Other specified cardiac arrhythmias
- ☐ R00.1 - Bradycardia, unspecified
- ☐ 150.9 - Heart Failure, unspecified
- ☐ 150.21 - Acute systolic (congestive) heart failure
- ☐ 150.22 - Chronic systolic(congestive) heart failure
- ☐ 150.32 - Chronic diastolic (congestive) heart failure
- ☐ 150.33 - Acute on chronic diastolic (congestive) heart failure
- ☐ 151.9 - Heart disease, unspecified
- ☐ 152 - Other heart diseases classified elsewhere
- ☐ R55 - Syncope and Collapse
- ☐ R60.0 - Localized edema
- ☐ E78.01 - Familial hypercholesterolemia
- ☐ R60.1 - Generalized edema
- ☐ R60.9 - Edema, unspecified
- ☐ R00.2 - Palpitations
- ☐ R06.02 - Shortness of breath
- ☐ R06.00 - Dyspnea, unspecified
- ☐ R06.09 - Other forms of dyspnea
- ☐ PR06.3 - Periodic breathing
- ☐ R06.83 - Snoring
- ☐ R06.89 - Other abnormalities of breathing
- ☐ R07.9 - Chest pain, unspecified
- ☐ R07.2 - Precordial pain
- ☐ R07.82 - Intercostal pain
- ☐ R07.89 - Other chest pain
- ☐ R94.31 - Nonspecific abnormal electrocardiogram (ECG)(EKG)
- ☐ Z79.01 - Long term (current) use of anticoagulants
- ☐ Z01.810 - Encounter for preprocedural cardiovascular examination
- ☐ Z01.812 - Encounter for preprocedural laboratory examination
- ☐ Z01.818 - Encounter for other preprocedural examination

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).

CARDIOVASCULAR TEST 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

CLINICAL TESTING AND PROCEDURES

LDL-C:..... Total Cholesterol:..... Age at Testing:.....

Procedures (e.g.: EKG, EHCO, etc.) Age:.....Result (e.g.: LVIDd. PWd, Qtc, etc):..... Type:.....

Cardiovascular Device implement (eh: Pacemaker, ICD, LVAD, etc.): Age at implementation:.....

INDICATIONS FOR TESTING (CHECK ALL THAT APPLY)

☐ Diagnostic ☐ Family history ☐ Positive or normal control ☐ Other .....

Will Patient management be changed depending on the test results? ☐Yes ☐ No ☐ STAT TEST : Date result needed (if Known):.....

PREVIOUS GENETIC TESTING (CHECK ALL THAT APPLY)

(PLEASE INCLUDE COPIES OF ANY PREVIOUS TEST RESULTS)	Test
Laboratory	Results

CARDIOVASCULAR PANEL

Cardiovascular genomics panel covers 68 Genes

☐ **Hypertrophic cardiomyopathy (14 Genes)**
ACTC1, ACTN2, CAV3, CSRP3, MYH6, MYL2, MYL3, MYLK2, MYOZ2, NEXN, PLN, TNNI3, TPM1, TTN.

☐ **Brugada Syndrome (8 Genes)**
CACNA1C, CACNB2, GPD1L, HCN4, KCNE3, SCN1B, SCN3B, SCN5A.

☐ **Familial atrial fibrillation (3 Genes)**
GJA5, KCNA5, KCNE2.

☐ **Dilated cardiomyopathy (20 Genes)**
ABCC9, ANKRD1, BAG3, CTF1, DES, DSG2, EYA4, LDB3, LMNA, PSEN1, PSEN2, RBM20, SGCD, TCAP, TMPO, TNNC1, VCL, FKTN, DMD, TAZ.

☐ **Left ventricular noncompaction cardiomyopathy (4 Genes)**
DTNA, MYBPC3, MYH7, TNNT2.

☐ **Congenital heart disease (3 Genes)**
PIGL, ZIC3, JAG1.

☐ **Arrhythmogenic right ventricular cardiomyopathy (7 Genes)**
DSC2, DSP, JUP, PKP2, RYR2, TGFB3, TMEM43.

☐ **Thoracic aortic aneurysms and dissection (7 Genes)**
ACTA2, FBN1, MYH11, MYLK, SMAD3, TGFBR1, TGFBR2.

☐ **Hereditary angiopathy with nephropathy (1 Gene)**
COL4A1.

☐ **Supravalvular aortic stenosis (1 Gene)**
ELN.

COMPREHENSIVE CARDIOVASCULAR PANEL GENES ☐

CACNA1C, CACNB2, GPD1L, HCN4, KCNE3, SCN1B, SCN3B, SCN5A, DSC2, DSG2, DSP, JUP, PKP2, RYR2, TGFB3,TMEM43, ABCC9, ACTC1, ACTN2, ANKRD1, BAG3, CSRP3, CTF1, DES, EYA4, LDB3, LMNA, MYBPC3, MYH6, MYH7, NEXN, PLN, PSEN1, PSEN2, RBM20, SGCD, TCAP, TMPO, TNNC1, TNNT2, TPM1, TTN, VCL, FKTN, TNNI3, DMD, TAZ, GJA5, KCNA5, KCNE2, DTNA, COL4A1, ELN, ACTA2, FBN1, MYH11, MYLK, SMAD3, TGFBR1, TGFBR2, PIGL, ZIC3, JAG1, CAV3, MYL2, MYL3, MYLK2, MYOZ2.

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

CARDIOVASCULAR TEST 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