



CLIA# 49D2178444 Laboratory Director: Dr. Shamaladevi Nagarajarao, Ph.D
 MicroGen Health, 14225 Sullyfield Circle, Suite E, Chantilly, Virginia 20151
 PH: 571-775-1973 Fax: 571-775-2012, Email: orders@microgenhealth.com, www.microgenhealth.com

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.

DIABETES REQUISITION FORM

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

PATIENT INFORMATION*		SPECIMEN INFORMATION* (For Phlebotomist service, select all services you are requesting)	
*First Name	Middle Name	<input type="checkbox"/> Buccal Swab	Medical Record#
*Last Name	*Date of Birth: MM / DD / YYYY	*Collection Date	*Collected By
Med Rec#/Patient Identifier	*Phone Number	<input type="checkbox"/> Specimen is post - mortem	Specimen ID
*Email	Date of death: MM / DD / YYYY		
Address	FAMILY HISTORY		
*City	*State	*Zip	Name (Person 1)
*Gender: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Others		Relation to Patient	Gender <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Others
Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other		Diagnosis and/or Symptoms	Age
		Name (Person 2)	DOB: MM / DD / YYYY
		Relation to Patient	Gender <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Others
		Diagnosis and/or Symptoms	Age
		Name (Person 3)	DOB: MM / DD / YYYY
		Relation to Patient	Gender <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Others
		Diagnosis and/or Symptoms	Age
		Sample Type <input type="radio"/> Blood <input type="radio"/> Buccal <input type="radio"/> Other	DOB: MM / DD / YYYY
<input type="checkbox"/> INSURANCE BILLING (Include copy of both sides of insurance card)		<input type="checkbox"/> INSTITUTIONAL BILLING* <input type="checkbox"/> SELF-PAY	
Patient Relation to Policy Holder? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		*Facility Name <input type="checkbox"/> Send Invoice to facility Address above	
Insurance Company	Policy#	HMO Auto#	*Address
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.			*Contact Name
<input type="checkbox"/> 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:			*Phone Number
<input type="checkbox"/> Email <input type="checkbox"/> Phone(includes tests) - confirm mobile #			*E-mail
Special Billing Notes:			Fax
			<input type="checkbox"/> PATIENT PAYMENT <input type="checkbox"/> Check (Payable To) <input type="checkbox"/> Credit Card

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
----------------------------	--------	-----------------------

DIABETES REQUISITION FORM

ICD-10 DIAGNOSIS CODES

- | | |
|---|---|
| <input type="checkbox"/> E11.42 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY | <input type="checkbox"/> E08.9 - DIABETES DUE TO UNDERLYING CONDITION W/O COMPLICATIONS |
| <input type="checkbox"/> E13.42 - OTH DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY | <input type="checkbox"/> E07.1 - DYSHORMOGENETIC GOITER |
| <input type="checkbox"/> E13.9 - OTHER SPECIFIED DIABETES MELLITUS WITHOUT COMPLICATIONS | <input type="checkbox"/> E11.43 - TYPE 2 DIABETES W DIABETIC AUTONOMIC (POLY)NEUROPATHY |
| <input type="checkbox"/> E11.65 - TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA | <input type="checkbox"/> E11.51 - TYPE 2 DIABETES W DIABETIC PERIPHERAL ANGIOPATHY W/O GANGRENE |
| <input type="checkbox"/> E04.0 - NONTOXIC DIFFUSE GOITER | <input type="checkbox"/> E11.630 - TYPE 2 DIABETES MELLITUS WITH PERIODONTAL DISEASE |
| <input type="checkbox"/> R73.03 - PREDIABETES | <input type="checkbox"/> E66.9 - OBESITY, UNSPECIFIED |
| <input type="checkbox"/> E11.40 - TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSP | |

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).

DIABETES REQUISITION FORM

TO BE FILLED IN BY PHYSICIAN

ORDER PROVIDER

*ICD-10 Codes

*Institution/Practice Name		*Institution Phone/Fax/Email		<input type="text"/>	<input type="text"/>
*Provider Last Name		*Provider First Name		<input type="text"/>	<input type="text"/>
*NPI	Provider Title			<input type="text"/>	<input type="text"/>
*Provider Address					
*City	*State/Province	*Zip Code	Country		
*Provider Phone	Fax Report to	*Primary Contact	*Primary Contact Phone/Email/Fax		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DIABETES TEST PANEL

<input type="checkbox"/> ABCC8 <input type="checkbox"/> BBS12 <input type="checkbox"/> CEL <input type="checkbox"/> GNAS <input type="checkbox"/> MAGEL2 <input type="checkbox"/> PDX1 <input type="checkbox"/> SDCCAG8 <input type="checkbox"/> ADRB2 <input type="checkbox"/> BBS2 <input type="checkbox"/> CEP290 <input type="checkbox"/> HNF1A <input type="checkbox"/> MC4R <input type="checkbox"/> POMC <input type="checkbox"/> SIM1 <input type="checkbox"/> ADRB3 <input type="checkbox"/> BBS4 <input type="checkbox"/> EIF2AK3 <input type="checkbox"/> HNF1B <input type="checkbox"/> MKKS <input type="checkbox"/> PPARG <input type="checkbox"/> TRIM32 <input type="checkbox"/> AGRP <input type="checkbox"/> BBS5 <input type="checkbox"/> ENPP1 <input type="checkbox"/> HNF4A <input type="checkbox"/> MKS1 <input type="checkbox"/> PPARGC1B <input type="checkbox"/> TTC8 <input type="checkbox"/> ALMS1 <input type="checkbox"/> BBS7 <input type="checkbox"/> FOXP3 <input type="checkbox"/> INS <input type="checkbox"/> NEUROD1 <input type="checkbox"/> PTF1A <input type="checkbox"/> UCP1 <input type="checkbox"/> ARL6 <input type="checkbox"/> BBS9 <input type="checkbox"/> GCK <input type="checkbox"/> KCNJ11 <input type="checkbox"/> NEUROG3 <input type="checkbox"/> PYY <input type="checkbox"/> UCP3 <input type="checkbox"/> BBS1 <input type="checkbox"/> BDNF <input type="checkbox"/> GHRL <input type="checkbox"/> LEP <input type="checkbox"/> NTRK2 <input type="checkbox"/> RFX6 <input type="checkbox"/> WDPCP <input type="checkbox"/> BBS10 <input type="checkbox"/> CARTPT <input type="checkbox"/> GLIS3 <input type="checkbox"/> LEPR <input type="checkbox"/> PCSK1 <input type="checkbox"/> SDC3 <input type="checkbox"/> WFS1	TEST OPTIONS Omitted test options will default to Seq & Del/Dup. Additional charges may apply. <input type="radio"/> Sequencing Only <input type="radio"/> Seq & Del/Dup <input type="radio"/> Del/Dup Only ORDER OPTIONS Additional charges may apply. <input type="checkbox"/> Prenatal <input type="checkbox"/> MCC <input type="checkbox"/> Exclude VUS <input type="checkbox"/> Rush/STAT REFLEX OPTIONS Reflex options may not be available for all tests. Additional charges will apply. <input type="radio"/> All-in-One (Extended) <input type="radio"/> Whole-in-One	INDICATIONS FOR TESTING Check all that apply. <input type="checkbox"/> Diagnostic <input type="checkbox"/> Family History <input type="checkbox"/> Presymptomatic <input type="checkbox"/> Other: <input type="checkbox"/> Family Variant CLINICAL/SUSPECTED DIAGNOSIS: Please attach medical records.
TEST SPECIFICS Ex: DUO/TRIO (needs additional information/consent for testing), known mutation(s), hold samples, and so on... <input type="checkbox"/> 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.		

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

COMPREHENSIVE DIABETES PANEL (56 GENES)

ABCC8, ADRB2, ADRB3, AGRP, ALMS1, ARL6, BBS1, BBS10, BBS12, BBS2, BBS4, BBS5, BBS7, BBS9, BDNF, CARTPT, CEL, CEP290, EIF2AK3, ENPP1, FOXP3, GCK, GHRL, GLIS3, GNAS, HNF1A, HNF1B, HNF4A, INS, KCNJ11, LEP, LEPR, MAGEL2, MC4R, MKKS, MKS1, NEUROD1, NEUROG3, NTRK2, PCSK1, PDX1, POMC, PPARG, PPARGC1B, PTF1A, PYY, RFX6, SDC3, SDCCAG8, SIM1, TRIM32, TTC8, UCP1, UCP3, WDPCP, WFS1.

CLINICAL HISTORY

DETAILS	FINDINGS	TESTING								
Check all that apply: <input type="checkbox"/> Bone Marrow Transplant <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Consanguinity <input type="checkbox"/> Mosaicism <input type="checkbox"/> Known Gene Gain/Loss <input type="checkbox"/> 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.	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.	Please indicate any clinical testing results and/or findings that may be relevant to genetic testing: <table style="width: 100%;"> <tr> <td>- Vision</td> <td>- Imaging</td> </tr> <tr> <td>- Biochemical Testing</td> <td>- Pathology Reports</td> </tr> <tr> <td>- Previous Genetic Testing</td> <td>- Karyotype</td> </tr> <tr> <td>- Hearing</td> <td>- Growth Measurements</td> </tr> </table> Please add tests that with negative results as well to assist our clinical staff in interpreting the findings of your examination.	- Vision	- Imaging	- Biochemical Testing	- Pathology Reports	- Previous Genetic Testing	- Karyotype	- Hearing	- Growth Measurements
- Vision	- Imaging									
- Biochemical Testing	- Pathology Reports									
- Previous Genetic Testing	- Karyotype									
- Hearing	- Growth Measurements									

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

DIABETES 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