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.

PARKINSON - ALZHEIMER - DEMENTIA 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
Med Rec#/Patient Identifier	*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*

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

Sample Type ○ Blood ○ Buccal ○ Other

☐ INSURANCE BILLING (Include copy of both sides of insurance card)

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

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 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

PARKINSON - ALZHEIMER - DEMENTIA REQUISITION FORM

ICD-10 DIAGNOSIS CODES

- ☐ G30.9 - ALZHEIMER'S DISEASE, UNSPECIFIED
- ☐ G31.84 - MILD COGNITIVE IMPAIRMENT, SO STATED
- ☐ G20 - PARKINSON'S DISEASE
- ☐ G30.0 - ALZHEIMER'S DISEASE WITH EARLY ONSET
- ☐ F03.90 - UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE
- ☐ E11.9 - TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS
- ☐ R68.89 - OTHER GENERAL SYMPTOMS AND SIGNS
- ☐ F03.91 - UNSPECIFIED DEMENTIA WITH BEHAVIORAL DISTURBANCE
- ☐ R41.2 - RETROGRADE AMNESIA
- ☐ G47.33 - OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
- ☐ F01.50 - VASCULAR DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE

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).

PARKINSON - ALZHEIMER - DEMENTIA REQUISITION FORM

TO BE FILLED IN BY PHYSICIAN

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**

PARKINSON-ALZHEIMER-DEMENTIA NGS TEST PANEL

Alzheimer's-dementia-Parkinson's genomics panel covers 35 genes

- ☐ **Alzheimer's Disease (7 Genes)** APOE, PSEN1, APP, MAPT, PSEN2, CSF1R, TREM2
- ☐ **Dementia (4 Genes)** PRNP, C9orf72, SNCB, TYROBP
- ☐ **Dystonia (3 Genes)** ATP1A3, PRKRA, TAF1
- ☐ **Perry Syndrome (1 Gene)** DCTN1
- ☐ **Parkinson's Disease (20 Genes)** GCH1, GRN, PINK1, DNMT1, SNCA, NOTCH3, TH, LRRK2, ATP13A2, EIF4G1, FBXO7, GBA, HTRA2, PARK7, PLA2G6, POLG, PRKN, SLC6A3, UCHL1, VPS35.

COMPREHENSIVE PARKINSON - ALZHEIMER - DEMENTIA PANEL GENES ☐

APOE, APP, ATP13A2, ATP1A3, C9orf72, CSF1R, DCTN1, DNMT1, EIF4G1, FBX07, GBA, GCH1, GRN, HTRA2, LRRK2, MAPT, NOTCH3, PARK7, PINK1, PLA2G6, POLG, PRKN, PRKRA, PRNP, PSEN1, PSEN2, SLC6A3, SNCA, SNCB, TAF1, TH, TREM2, TYROBP, UCHL1, VPS35.

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.

☐ Rush/STAT ☐ Prental ☐ Exclude VUS

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.

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

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.

CLINICAL HISTORY

DETAILS	FINDINGS	TESTING
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.	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: - 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 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

PARKINSON - ALZHEIMER - DEMENTIA 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