MicroGen HEALTH

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

PULMONARY 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

Date of Death: MM / DD / YYYY (if applicable) | *Phone Number

Email*

*Address

*City *State *Zip

*Gender: ○ Male ○ Female ○ Others

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

☐ Buccal Swab | Medical Record#

*Collection Date | *Collected By | Specimen ID

FAMILY HISTORY*

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

Relationship to patient..... ☐ Maternal ☐ Paternal

Diagnosis .....Dx age.....

Relationship to patient..... ☐ Maternal ☐ Paternal

Diagnosis .....Dx age.....

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

Phlebotomist Service Request: ☐ Phlebotomist ☐ Insurance preverification first ☐ Send kit to patient

*As the patient's clinician, I am unaware of any potential for complication or difficulty in drawing blood for the listed patient (s). I understand that phlebotomist has full authority to refuse to draw any patient if the safety of the phlebotomist and / or patient (s) are in question.

PATIENT HISTORY ☐ No personal history of pulmonology disease

PLEASE SUPPLY CLINIC NOTES AND PEDIGREE If pregnant, Due Date: MM / DD / YYYY Upcoming Procedure Date: MM / DD / YYYY

☐ **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

PULMONARY TEST REQUISITION FORM

ICD-10 DIAGNOSIS CODES WITH DESCRIPTION

- ☐ C34.1 - Malignant Neoplasm of upper lobe, right bronchus or lung
- ☐ C34.12 - Malignant Neoplasm of upper lobe, left bronchus or lung
- ☐ C34.2 - Malignant Neoplasm of Middle lobe, bronchus or lung
- ☐ C34.31 - Malignant Neoplasm of lower lobe, right bronchus or lung
- ☐ C34.32 - Malignant Neoplasm of lower lobe, left bronchus or lung
- ☐ G47.33 - Obstructive sleep apnea
- ☐ I27.0 - Primary Pulmonary Hypertension
- ☐ J44.1 - Chronic Obstructive Pulmonary Disease with acute exacerbation
- ☐ J44.9 - Chronic Obstructive Pulmonary disease NOS
- ☐ J20.0 - Acute bronchitis due to Mycoplasma pneumoniae
- ☐ J20.1 - Acute bronchitis due to Hemophilus influenzae
- ☐ J20.3 - Acute bronchitis due to coxsackievirus
- ☐ J45.30 - Mild Persistent Asthma
- ☐ J45.32 - Mild Persistent Asthma with status asthmaticus
- ☐ J45.41 - Moderate persistent Asthma with acute exacerbation
- ☐ R91.8 - Nonspecific abnormal finding of lung field in diagnostic imaging
- ☐ R94.2 - Abnormal results of pulmonary function studies
- ☐ A41.9 - Sepsis, unspecified organism Malignant neoplasm of trachea, bronchus, lung
- ☐ C33 - Trachea
- ☐ J20.5 - Acute bronchitis due to respiratory syncytial virus
- ☐ J20.6 - Acute bronchitis due to rhinovirus
- ☐ J20.7 - Acute bronchitis due to echovirus
- ☐ J20.8 - Acute bronchitis due to other specified organisms
- ☐ J28.0 - Acute pulmonary Edema
- ☐ R06.02 - Shortness of Breath
- ☐ R06.2 - Sweezing | R05-Cough
- ☐ R07.1 - Chest pain on breathing
- ☐ R07.81 - Pleurodynia
- ☐ J45.31 - Mild Persistent Asthma with acute exacerbation
- ☐ J45.40 - Moderate persistent Asthma
- ☐ J45.42 - Moderate persistent Asthma with status asthmaticus
- ☐ J45.909 - Unspecified asthma, uncomplicated
- ☐ J44.9 - Chronic obstructive pulmonary disease, unspecified
- ☐ J90 - Pleural effusion, not elsewhere classified
- ☐ J98.11 - Atelectasis
- ☐ J98.19 - Other pulmonary collapse
- ☐ J98.2 - Interstitial emphysema
- ☐ J81.0 - Acute pulmonary edema

ICD-10 DIAGNOSIS CODES WITH DESCRIPTION

- ☐ C34.30 - Lower lobe bronchus or lung
- ☐ C34.80 - Overlapping sites of unspecified bronchus or lung
- ☐ G47.33 - Obstructive sleep apnea (adult) (pediatric)
- ☐ I26.99 - Other pulmonary embolism without acute corpulmonale
- ☐ I95.9 - Hypotension, unspecified
- ☐ J20.1 - Acute bronchitis due to Hemophilius influenzae
- ☐ J20.2 - Acute bronchitis due to streptococcus
- ☐ J20.4 - Acute bronchitis due to parainfluenza virus
- ☐ J20.9 - Acute bronchitis, unspecified
- ☐ J16.8 - Pneumonia due to other specified infectious organisms
- ☐ J18.9 - Pneumonia, unspecified organism
- ☐ J40 - Bronchitis, not specified as acute or chronic
- ☐ J45.20 - Mild Intermittent Asthma
- ☐ J45.23 - Mild Intermittent Asthma with status asthmaticus
- ☐ J45.21 - Mild Intermittent Asthma with acute exacerbation
- ☐ J45.52 - Severe persistent Asthma with status asthmaticus
- ☐ J45.50 - Severe persistent Asthma
- ☐ J45.51 - Severe persistent Asthma with acute exacerbation
- ☐ C34.00 - Unspecified main bronchus
- ☐ C34.10 - Upper lobe unspecified bronchus or lung
- ☐ J96.0 - Acute respiratory failure
- ☐ J96.02 - Acute respiratory failure with hypercapnia
- ☐ J96.10 - Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
- ☐ J96.11 - Chronic respiratory failure with hypoxia
- ☐ J96.12 - Chronic respiratory failure with hypercapnia
- ☐ J96.20 - Acute/Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
- ☐ J96.21 - Acute/Chronic respiratory failure with hypoxia
- ☐ J96.22 - Acute/Chronic respiratory failure with hypercapnia
- ☐ N17.9 - Acute kidney failure, unspecified
- ☐ R09.89 - Other specified symptoms and signs involving the circulatory and respiratory systems
- ☐ R05 - Cough
- ☐ R22.2 - Localized swelling, mass and lump, trunk (chest mass) (localized swelling of chest)
- ☐ R91.1 - Solitary pulmonary nodule
- ☐ R09.02 - Hypoxemia
- ☐ J98.4 - Other disorders of lung
- ☐ R65.20 - Severe sepsis without septic shock (sequence the underlying infection first)
- ☐ Z85.118 - Personal history of malignant neoplasm of bronchus and lung
- ☐ Z79.01 - Long-term (current) use of anticoagulants
- ☐ J95.84 - Transfusion related acute lung injury (TRALI)
- ☐ J96.00 - Acute respiratory failure, unspecified whether with hypoxia or hypercapnia

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).

PULMONARY 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

INDICATIONS FOR TESTING (CHECK ALL THAT APPLY)

Will patient management be changed depending on the test result?

☐ Yes ☐ No ☐ STAT TEST: Date result Needed (if Known) .....

REASONS FOR TESTING

☐ Positive newborn screen

☐ Infections: .....

☐ Sweat chloride:.....mmol/L

☐ Sweat chloride: ☐ <40 ☐ 40-60 ☐ <60

☐ CBACD

☐ Meconium ileus

☐ Pancreatic insufficiency IRT level:.....

☐ Respiratory distress, explain:.....

☐ Ultrasound findings:.....

☐ Pancreatic insufficiency IRT level:.....

☐ Respiratory distress, explain:.....

☐ Ultrasound findings:.....

☐ Other:.....

Relevant lab results (include copies if possible)

PATIENT HISTORY FOR PULMONARY TESTING

Does the patient have symptoms? (if yes, check all that apply) ☐ No ☐ Yes ☐ Unknown

☐ PAH

☐ Pulmonary capillary hemangiomatosis (PCH) ☐ Fatigue ☐ Fatigue

☐ Pulmonary veno-occlusive disease (PVOD) ☐ Palpitation ☐ Palpitation

☐ Shortness of breath ☐ Others.....

☐ Syncope

Does the patient have other risk factors for pulmonary hypertension? ☐ No ☐ Yes (Check all that apply) ☐ Unknow

☐ Lung disease ☐ Heart disease ☐ Cirrhosis

☐ Pulmonary embolism ☐ Connective tissue disease ☐ HIV ☐ Others.....

Has the patient's mean pulmonary artery pressure been measured? ☐ No ☐ Yes ☐ Unknow

If yes, what was result at rest?.....mmHg ☐ No ☐ Abnormal ☐ Unknow

What was result during exercise?.....mmHg ☐ No ☐ Abnormal ☐ Unknow

Has the patient undergone previous DNA testing for this condition? ☐ No ☐ Yes ☐ Unknow

If Yes, describe the test performed and result :.....

Is there any relevant family history? ☐ No ☐ Yes ☐ Unknow

If Yes, attach a pedigree or specify the Relative's Relationship to the patient. List their symptoms and age of onset:.....

.....

GENETIC COUNSELING ☐

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

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.

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

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.

INFORMED CONSENT ☐

Patient must consent

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.

PULMONARY TEST REQUISITION FORM

PULMONARY TEST PANEL

Pulmonary genomics panel covers 67 genes

- ☐ **Ciliary Dyskinesia (26 Genes)**
  CCDC39, CCDC40, DNAAF1, DNAAF2, DNAH1, DNAH11, DNAH5, DNAI2, DNAI1, DKC1, DNAL1, GAS8, NAF1, NF1, NKX2-1, NME8, PIH1D3, RET, RSPH3, RSPH4A, RSPH9, PARN, PHOX2B, ITGA3, MECP2, ZEB2.
- ☐ **Bronchiectasis (4 Genes)**
  SERPINA1, SLC34A2, SCNN1A, SCNN1B.
- ☐ **Cutis Laxa (7 Genes)**
  EFEMP2, EDN3, ELN, FBLN5, FLCN, FOXF1, LTBP4.
- ☐ **Tuberous Sclerosis (2 Genes)**
  TSC1, TSC2.
- ☐ **Lysinuric Protein Intolerance (3 Genes)**
  SCN4A, STAT3, SLC7A7.
- ☐ **Myasthenic Syndrome (7 Genes)**
  CHAT, CHRNA1, CHRNB1, CHRND, CHRNE, COLQ, RAPSN.
- ☐ **Pulmonary Fibrosis (4 Genes)**
  ELMOD2, RTEL1, SFTPA1, SFTPA2.
- ☐ **Hermansky-Pudlak Syndrome (2 Genes)**
  HPS1, HPS4.
- ☐ **Hyperekplexia (2 Genes)**
  GLRA1, SLC6A5.
- ☐ **Surfactant Metabolism Dysfunction (5 Genes)**
  ABCA3, CSF2RA, CSF2RB, SFTPB, SFTPC.
- ☐ **Cystic Fibrosis (1 Gene)**
  CFTR.
- ☐ **Dyskeratosis Congenita (3 Genes)**
  TERC, TERT, TINF2.
- ☐ **Neimann-Pick Disease A/B (1 Gene)**
  SMPD1.

COMPREHENSIVE PULMONARY PANEL GENES ☐

ABCA3, CCDC39, CCDC40, CFTR, CHAT, CHRNA1, CHRNB1, CHRND, CHRNE, COLQ, CSF2RA, CSF2RB, DKC1, DNAAF1, DNAAF2, DNAH1, DNAH11, DNAH5, DNAI1, DNAI2, DNAL1, EDN3, EFEMP2, ELMOD2, ELN, FBLN5, FLCN, FOXF1, GAS8, GLRA1, HPS1, HPS4, ITGA3, LTBP4, MECP2, NAF1, NF1, NKX2-1, NME8, PARN, PHOX2B, PIH1D3, RAPSN, RET, RSPH3, RSPH4A, RSPH9, RTEL1, SCN4A, SCNN1A, SCNN1B, SERPINA1, SFTPA1, SFTPA2, SFTPB, SFTPC, SLC34A2, SLC6A5, SLC7A7, SMPD1, STAT3, TERC, TERT, TINF2, TSC1, TSC2, ZEB2.

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

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