Quest Diagnostics™

Exome with CNV Evaluation Requisition

BILL TO:
- ☐ My Account
- ☐ Insurance Provided
- ☐ Lab Card/Select
- ☐ Patient

PRINT PATIENT NAME (LAST, FIRST, MIDDLE)

REGISTRATION # (IF APPLICABLE) | DATE OF BIRTH M M D D YEAR | SEX

PATIENT EMAIL ADDRESS | **PATIENT ID # / MRN**

CELL PHONE ( ) | **PATIENT PHONE** ( )

PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT

PATIENT STREET ADDRESS (OR INSURED/RESPONSIBLE PARTY) APT. # KEY #

CITY | STATE | ZIP

ACCOUNT #:

NAME:

ADDRESS:
CITY, STATE, ZIP

TELEPHONE #:

DID YOU KNOW

IMPORTANT! THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY.

Each sample should be labeled with at least two patient identifiers at time of collection.

ICD Diagnosis Codes are Mandatory. Fill in the applicable fields below.

DATE COLLECTED | TIME : ☐ AM ☐ PM | TOTAL VOL/HRS. _____ ML _____ HR | ☐ Fasting ☐ Non Fasting

NPI/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYERS (MUST BE INDICATED)

☐ ADDL PHYS: Dr._____ NPI/UPIN

NON-PHYSICIAN PROVIDER: | NAME | I.D.#

☐ Fax Results to: ( )_____

Send Duplicate Report to:
Client # OR NAME:_____
ADDRESS:_____
CITY:_____ STATE_____ ZIP_____

INSURANCE

Primary Insurance ☐ Medicare ☐ Medicaid ☐ Other
Insurance Company Name _____
ID # _____ Group # _____
Insurance Address _____
Patient Is: ☐ Subscriber ☐ Spouse ☐ Other Dependent

Secondary Insurance ☐ Medicare ☐ Medicaid ☐ Other
Insurance Company Name _____
ID # _____ Group # _____
Insurance Address _____
Patient Is: ☐ Subscriber ☐ Spouse ☐ Other Dependent

ABN required for tests with these symbols

Medicare Limited Coverage Tests

@ = May not be covered for the reported diagnosis.
F = Has prescribed frequency rules for coverage.
& = A test or service performed with research/experimental kit.
B = Has both diagnosis and frequency-related coverage limitations.

Provide signed ABN when necessary

Visit QuestDiagnostics.com/MLCP for Medicare coverage guidelines

ICD Codes (enter all that apply)

THIS REQUISITION MUST BE ACCOMPANIED BY THE CLINICAL HISTORY FORM. FAILURE TO DO SO MAY RESULT IN DELAYED REPORTING AND POSSIBLE INCORRECT INTERPRETATION. FORMS AVAILABLE THROUGH YOUR LOCAL REPRESENTATIVE OR BY VISITING WWW.QUESTEXOME.COM

Exome with CNV Evaluation

36935 ☐ **Exome with CNV Evaluation, Proband**
Please submit 8 mL (6 mL min) whole blood in 2 EDTA (lavender top) tubes. Pediatric (0-3 years) 2 mL (1 mL min).

36936 ☐ **Exome with CNV Evaluation, Trio**
Please submit 8 mL (6mL min) whole blood in 2 EDTA (lavender top) tubes for each member of the trio as well as a requisition with test code 36939 checked for each family member being tested.

Family Member Name:_____ DOB:_____
Relationship to Proband:_____
Family Member Name:_____ DOB:_____
Relationship to Proband:_____

36937 ☐ **Exome with CNV Evaluation, Duo**
Please submit 8 mL (6mL min) whole blood in 2 EDTA (lavender top) tubes for the other family member as well as a requisition with test code 36939 checked for the family member being tested.

Family Member Name:_____ DOB:_____
Relationship to Proband:_____

36938 ☐ **Exome with CNV Evaluation, Reanalysis**
Do not send a new sample, this is for data reanalysis only. Please submit new clinic notes and phenotype information using the clinical history form.

TO ORDER REANALYSIS PLEASE CALL 1.866.GENE.INFO AND ASK TO SPEAK TO A GENOMIC SCIENCE SPECIALIST

Original Accession#:_____

Original Date of Service:_____

36939 ☐ **Exome with CNV Evaluation, Family Member**
Please note that this test code does not result in a report for the family member and is only used to help analyze the proband test result.

Primary Patient Name:_____ DOB:_____

RACE/ETHNICITY - Important for Accurate Test Interpretation - Please check all that apply

- ☐ Ashkenazi (Eastern European) Jewish
- ☐ Sephardic Jewish
- ☐ African/African American
- ☐ Hispanic/Latino
- ☐ European Caucasian
- ☐ Asian
- ☐ Other:_____

Please fax this requisition and fully-completed Clinical History Form to 1.949.668.7818

If you have questions regarding this order, please call 1.866.GENE.INFO to speak with a Genomic Science Specialist or email exomeGC@questdiagnostics.com

REQUIRED SIGNATURES

PATIENT ACKNOWLEDGEMENT
I authorize Quest Diagnostics (Quest) to release information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize my health plan/insurance carrier to directly pay Quest for the services rendered. I understand that I may be responsible for portions of this test not covered by my insurance.

SIGNATURE REQUIRED

Patient Signature _____ Date _____

STATEMENT OF MEDICAL NECESSITY AND INFORMED CONSENT
I have supplied information to the patient regarding genetic testing and the patient has given consent for genetic testing to be performed. I further confirm that this test is medically necessary for the diagnosis or detection of disease, illness, impairment, symptom, syndrome, or disorder and the results will be used in the medical management and treatment decisions for the patient. I confirm that the person listed in the Ordering Physician space above is authorized by law to order the test(s) requested herein.

SIGNATURE REQUIRED

Medical Professional's Signature X _____ Date _____

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.