Cardiology Genetics 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

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.

ACCOUNT #:
NAME:
ADDRESS:
CITY, STATE, ZIP
TELEPHONE #:

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

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

☐ ADDIT'L 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.
FORM AVAILABLE THROUGH YOUR LOCAL REPRESENTATIVE OR BY VISITING WWW.QUESTCARDIOGENETICS.COM

Familial Hypercholesterolemia (FH)

94877 ☐ **Familial Hypercholesterolemia Panel**
(*LDLR, APOB, PCSK9* sequencing and deletion/duplication)

94878 ☐ **Familial Hypercholesterolemia Single site**
(Single site test can be ordered for *LDLR, APOB* or *PCSK9)*

Gene Name: __________ Mutation Name: __________
NOTE: Copy of family member's report MUST be submitted.

For fastest processing, please fax this requisition and fully-completed Clinical History Form to 855.422.5181

If you have questions regarding this order, please call 866.GENE.INFO

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.

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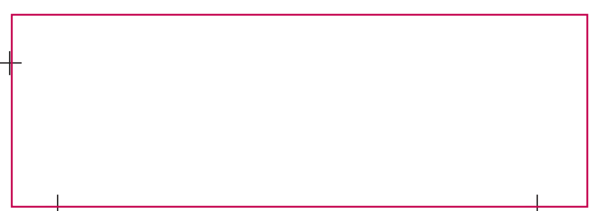

SPECIMEN KEY ON BACK
Provide signed ABN when necessary
FOLD HERE
SMOOTHSEAL®
ICD Diagnosis Codes are Mandatory. Fill in the applicable fields below.
Provide signed ABN when necessary

All samples to be shipped ambient, unless otherwise specified.

Specimen Key:	L	=	Lavender top tube

Consider taking advantage of our convenient scheduling. Visit us at QuestDiagnostics.com/appointment or call 888-277-8772 or simply download our mobile app. at QuestDiagnostics.com/mobile

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CITY | STATE | ZIP

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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 ________________
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FOLD HERE

SPECIMEN KEY ON BACK

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