BAYLOR GENETICS
READY WITH ANSWERS

SHIPPING Baylor Genetics
2450 Holcombe Blvd., Grand Blvd. Receiving Dock
Houston, TX 77021-2024
Phone: 713.798.6555
Fax: 713.798.2787

GENEAWARE REQUISITION FORM

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name | Patient First Name | MI | Date of Birth (MM/DD/YY) ___/___/___

Address | Accession # | Hospital/ Medical Record #

Biological Sex: ◯ M ◯ F ◯ Unknown

City | State | Zip | Phone

Gender identity (if different from above):

REPORTING RECIPIENTS

Ordering Physician | Institution Name

Email (Required for International Clients) | Phone | Fax

ADDITIONAL RECIPIENTS

Name | Name

Email | Fax | Email | Fax

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

☐ **SELF PAYMENT (REQUIRED**: Patient Billing Consent and Payment Form Attached)

☐ **INSTITUTIONAL BILLING**

Institution Name | Institution Code | Institution Contact Name | Institution Phone | Institution Contact Email

☐ **INSURANCE**

☐ Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)

REQUIRED ITEMS
1. Copy of the Front/Back of Insurance Card(s)
2. ICD10 Diagnosis Code(s)
3. Name of Ordering Physician
4. Insured Signature of Authorization

Name of Insured | Insured Date of Birth (MM/DD/YY) ___/___/___ | Address of Insured

Patient's Relationship to Insured | Phone of Insured | City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone | Primary Member Policy # | Primary Member Group #

Secondary Insurance Co. Name | Secondary Insurance Co. Phone | Secondary Member Policy # | Secondary Member Group #

By signing below, I hereby authorize Baylor Genetics to provide my designated insurance carrier any information necessary, including test results, for processing my insurance claim. I also authorize benefits to be payable exclusively to Baylor Genetics. I understand that my insurance carrier may not approve or reimburse my medical genetic services in full or any portion thereof, due to a variety of reasons, including, but not limited to: the contract status of my insurance provider with Baylor Genetics, usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates. I understand that I am responsible for any amounts not paid by my insurance carrier for reasons including, but not limited to,non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics. any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

Patient's Name | Patient's Signature | Date

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name | Physician's Signature | Date

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Patient Last Name ______ Patient First Name ______ MI ______ Date of Birth (MM/DD/YY) ___/___/___ Biological Sex ______

ETHNICITY

- ◯ African American
- ◯ Ashkenazi Jewish
- ◯ East Asian (China, Japan, Korea)
- ◯ Finnish
- ◯ French Canadian
- ◯ Hispanic American
- ◯ Mennonite
- ◯ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
- ◯ Native American
- ◯ Northern European Caucasian (Scandinavian, UK, Germany)
- ◯ Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
- ◯ South Asian (India, Pakistan)
- ◯ Southeast Asian (Vietnam, Cambodia, Thailand)
- ◯ Southern European Caucasian (Spain, Italy, Greece)
- ◯ Other (Specify) ______

SAMPLE

Date of Collection (MM/DD/YY) ___/___/___

SAMPLE TYPE

- ◯ Blood (Collected in 4 cc EDTA tube with GeneAware barcode)
- ◯ Saliva (Collected in GeneAware kit)

CARRIER TESTING PANELS

FEMALE	**MALE**
◯ 60401 - Basic	◯ 60406 - Basic
◯ 60301 - ACMG and ACOG	◯ 60306 - ACMG and ACOG
◯ 60201 - Ashkenazi Jewish	◯ 60206 - Ashkenazi Jewish
◯ 60101 - Complete	◯ 60106 - Complete

INDICATION FOR CARRIER TESTING (REQUIRED)

- ◯ No Family History
- ◯ Patient Known Carrier *
- ◯ Partner Known Carrier *
- ◯ Known Family History *(Specify relationship) ______
- ◯ Male Infertility / Female Infertility
- ◯ Family History of Consanguinity
- ◯ Egg / Sperm Donor
- ◯ Abnormal Fetal Ultrasound (Specify) ______

** Please provide the below information and attach report, if applicable.*

Disease ______

Gene ______ Variant ______

Is Patient or Patient's Partner Currently Pregnant? ◯ YES ◯ NO
Testing is not available to minors, unless pregnant.

If Yes, please specify Gestational Age:

U/S Date (MM/DD/YY) ___/___/___

LMP Date (MM/DD/YY) ___/___/___

Gestational Age on U/S Date: ______ Weeks ______ Days

ICD10 Diagnosis Code(s) ______

MERGED COUPLE REPORTS FOR GENEAWARE PANELS

NOTE: If an individual's sample is submitted after their partner's sample has already been submitted, and the couple wishes to have a merged report, both results will be held until all testing is completed in order to produce a merged report. This may cause the couple's merged report to be sent out longer than 14 days from the first sample submitted, but within 14 days of the second sample submitted.

Patient Last Name ______ Patient First Name ______ MI ______ Date of Birth (MM/DD/YY) ___/___/___

◯ Couple Sent Together ◯ Partner Sent Previously

Baylor Lab # ______ Family # ______

By agreeing to this informed consent, you provide authorization for your results to be disclosed to your ordering physician and other covered entities. If both you and your partner are being tested simultaneously or if your results are subsequently merged, you are authorizing the release of your results to your partner's healthcare provider, which may include sensitive medical information. Your results may become part of your partner's medical record, which is available to your partner's physician and other covered entities.

IF NOT SIGNED, SEPARATE REPORTS WILL BE ISSUED

Patient Name ______ Date of Birth (MM/DD/YY) ___/___/___ Partner Name ______ Date of Birth (MM/DD/YY) ___/___/___

Patient Signature ______ Date ______ Partner Signature ______ Date ______