

## GENEAWARE REQUISITION

### PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name \_\_\_\_\_ Patient First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth (MM / DD / YYYY) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Accession # \_\_\_\_\_ Hospital / Medical Record # \_\_\_\_\_  
 Biological Sex:  Female  Male  Unknown  
 Gender identity (if different from above): \_\_\_\_\_

### REPORTING RECIPIENTS

Ordering Physician \_\_\_\_\_ Institution Name \_\_\_\_\_  
 Email (Required for International Clients) \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

### ADDITIONAL RECIPIENTS

Name \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_  
 Name \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_

### PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

**SELF PAYMENT** .....  
 Pay With Sample  Bill To Patient

**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 / YYYY) _____	Name of Insured _____	Insured Date of Birth (MM / DD / YYYY) _____
Patient's Relationship to Insured _____	Phone of Insured _____	Patient's Relationship to Insured _____	Phone of Insured _____
Address of Insured _____		Address of Insured _____	
City _____	State _____ Zip _____	City _____	State _____ Zip _____
Primary Insurance Co. Name _____	Primary Insurance Co. Phone _____	Secondary Insurance Co. Name _____	Secondary Insurance Co. Phone _____
Primary Member Policy # _____	Primary Member Group # _____	Secondary Member Policy # _____	Secondary Member Group # _____

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates, as well as 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 Printed Name \_\_\_\_\_ Patient's Signature \_\_\_\_\_ Date (MM / DD / YYYY) \_\_\_\_\_

### 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 (MM / DD / YYYY) \_\_\_\_\_

