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

CUSTOM FAMILY SEQUENCING REQUISITION

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**

◯ Bill Patient For Laboratory Testing

☐ **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
- ◯ Saliva
- ◯ DNA (Specify Source): _____
- ◯ Other (Specify): _____

INDICATION FOR TESTING (REQUIRED)

ICD10 Diagnosis Code(s) _____

CUSTOM FAMILY SEQUENCING INFORMATION

Test Codes 1580-1589 are to be used when requesting sequencing of a known familial variant(s) for which the Baylor Genetics does not provide a separate test code. These should only be used when the Baylor Genetics has already identified the sequence change in the proband/original patient. If proband testing was performed at another lab, call to discuss prior to sending sample. A positive control may be required in some cases. If testing of proband is needed, see separate requisition "Proband Custom Sequencing Analysis," which can be found at www.BMGL.com.

Name of First Patient Studied | Relationship to Patient Studied | Baylor Genetics Lab # | Family #

This Family Member is Currently: ☐ Asymptomatic ☐ Symptomatic

If SYMPTOMATIC, please provide details. Please attach additional pages, if needed.

Include a pedigree showing familial relationships.

☐ Copy of Original Results Attached (REQUIRED)

CUSTOM FAMILY SEQUENCING TESTS

Please select one test code per gene for which targeted sequencing is being ordered:

TEST CODE		TEST NAME	GENE NAME (REQUIRED)	MUTATION/UNCLASSIFIED VARIANT (REQUIRED)
☐	1580	Custom Family Member Sequence Analysis - Gene 1		
☐	1581	Custom Family Member Sequence Analysis - Gene 2		
☐	1582	Custom Family Member Sequence Analysis - Gene 3		
☐	1583	Custom Family Member Sequence Analysis - Gene 4		
☐	1584	Custom Family Member Sequence Analysis - Gene 5		
☐	1585	Custom Family Member Sequence Analysis - Gene 6		
☐	1586	Custom Family Member Sequence Analysis - Gene 7		
☐	1587	Custom Family Member Sequence Analysis - Gene 8		
☐	1588	Custom Family Member Sequence Analysis - Gene 9		
☐	1589	Custom Family Member Sequence Analysis - Gene 10		