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 PROBAND 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 PROBAND SEQUENCING INFORMATION

This requisition is for request of confirmation of TARGETED variant(s) testing:

· Confirmation of test results that has not previously been completed in a CLIA/CAP lab (such as research lab results)

This requisition should only be used for confirmation of genes which Baylor Genetics does not provide a separate specific test code.

REQUIRED: Lab report which identified mutation originally must be included with this requisition. We will not be able to proceed with testing without documentation from the laboratory that identified the change. The lab report should include the mutation names at nucleotide level and if applicable, amino acid level and/or reference sequence number including version number (Ex: NM_000314.4). NOTE: We are unable to accept samples from a research facility.

If TARGETED testing on FAMILY member of the proband is desired either after or in conjunction with the proband's testing, please complete the "Family Member Custom Sequencing Requisition" for each family member available on our website www.BMGL.com (See Test Code 1580).

CUSTOM PROBAND SEQUENCING TESTS

◆ **FOR AUTOSOMAL DOMINANT, HOMOZYGOUS OR X-LINKED TARGETED GENE TESTING**

Use the below test codes (1560-1569) for requests when confirmation of only ONE sequence change is being requested for that gene (i.e. autosomal dominant inheritance). Complete one test code request for EACH gene.

TEST CODE		TEST NAME	GENE NAME (REQUIRED)	MUTATION/UNCLASSIFIED VARIANT (REQUIRED)
☐	1560	Custom Proband Sequence Analysis - Gene 1		
☐	1561	Custom Proband Sequence Analysis - Gene 2		
☐	1562	Custom Proband Sequence Analysis - Gene 3		
☐	1563	Custom Proband Sequence Analysis - Gene 4		
☐	1564	Custom Proband Sequence Analysis - Gene 5		
☐	1565	Custom Proband Sequence Analysis - Gene 6		
☐	1566	Custom Proband Sequence Analysis - Gene 7		
☐	1567	Custom Proband Sequence Analysis - Gene 8		
☐	1568	Custom Proband Sequence Analysis - Gene 9		
☐	1569	Custom Proband Sequence Analysis - Gene 10		

SEE NEXT PAGE FOR RECESSIVE TESTING OPTIONS

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

CUSTOM PROBAND SEQUENCING TESTS

◆ **FOR AUTOSOMAL RECESSIVE TARGETED GENE TESTING**

Use the below test codes (1570-1579) for requests when confirmation of TWO sequence changes are being requested for that gene (i.e. autosomal recessive inheritance). Complete one test code for EACH gene that TWO sequence changes are being confirmed.

	TEST CODE	TEST NAME	GENE NAME (REQUIRED)	FIRST: MUTATION/UNCLASSIFIED VARIANT (REQUIRED)	SECOND: MUTATION/UNCLASSIFIED VARIANT (REQUIRED)
☐	1570	Custom Proband Sequence Analysis - Gene 1			
☐	1571	Custom Proband Sequence Analysis - Gene 2			
☐	1572	Custom Proband Sequence Analysis - Gene 3			
☐	1573	Custom Proband Sequence Analysis - Gene 4			
☐	1574	Custom Proband Sequence Analysis - Gene 5			
☐	1575	Custom Proband Sequence Analysis - Gene 6			
☐	1576	Custom Proband Sequence Analysis - Gene 7			
☐	1577	Custom Proband Sequence Analysis - Gene 8			
☐	1578	Custom Proband Sequence Analysis - Gene 9			
☐	1579	Custom Proband Sequence Analysis - Gene 10			