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

OVERGROWTH PANELS 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

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

OVERGROWTH PANELS REQUISITION

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) ____

INDICATION FOR TESTING (REQUIRED)

ICD10 Diagnosis Code(s): ____

TEST OPTION

A

- **AFFECTED TISSUE** (Choose one of the following)
  - ☐ 9720 - Fresh Tissue
  - ☐ 9720 - Cultured Cells (two T-25 flasks)

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

  ☐ To Be Sent Later

- **UNAFFECTED TISSUE** (Choose one of the following)
  - ☐ 9141 - Fresh Tissue
  - ☐ 9141 - Cultured Cells (two T-25 flasks)
  - ☐ 9141 - Whole Blood (5 mL in EDTA (purple-top) tube)

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

  ☐ To Be Sent Later

Note: Please send both affected and unaffected tissues simultaneously. If not, send a copy of this form with each tissue.

B

- **UNAFFECTED TISSUE ONLY (AFFECTED TISSUE IS UNAVAILABLE)**

  NOTE: It is preferred to receive both affected and unaffected tissues. Not testing an affected tissue may decrease likelihood of detecting a mutation.

  - ☐ 9720 - Whole Blood (5 mL in EDTA (purple-top) tube)

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

BILLING 713.798.3566 | billing@bmgl.com GENERAL 800.411.GENE | genetictest@bmgl.com BMGL.COM

UPDATED 12.2016