

CGC Genetics CLIA#: 99D1066287

IGM-UMDNJ CLIA#: 31D1085261 - CAP#: 7215375

Insurance OR Pre-Payment Test Requisition - January 2014

\* Indicates REQUIRED information (where applicable)

## Patient ID

### Patient Identification

Patient Name\* First \_\_\_\_\_ Last \_\_\_\_\_

Patient ID # (if available) \_\_\_\_\_

S.S. # \_\_\_\_\_ Date of Birth\* mm / dd / yy \_\_\_\_\_

Sex\* ☐ Male ☐ Female ☐ Unknown

Ethnicity\* ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic

☐ Jewish ☐ Specify \_\_\_\_\_

Mailing Address\* \_\_\_\_\_

City\* \_\_\_\_\_ State\* \_\_\_\_\_ Zip\* \_\_\_\_\_ Country\* \_\_\_\_\_

Phone #1\* \_\_\_\_\_ ☐ Day ☐ Eve ☐ Cell

Phone #2 \_\_\_\_\_ ☐ Day ☐ Eve ☐ Cell

### Patient Insurance Information • Option 1

Please provide a photocopy of the front and back of the insurance card.

Name of insured\* First \_\_\_\_\_ Last \_\_\_\_\_

Relationship to Patient:\* ☐ Self ☐ Parent ☐ Spouse ☐ Other

Member ID #\* \_\_\_\_\_

Group ID #\* \_\_\_\_\_

Insurance Company Name\* \_\_\_\_\_

Address\* \_\_\_\_\_

City\* \_\_\_\_\_ State\* \_\_\_\_\_ Zip\* \_\_\_\_\_ Country\* \_\_\_\_\_

Phone \_\_\_\_\_

#### Appeal Authorization

In the event of an underpayment or denial by my insurance carrier, I hereby authorize CGC Genetics or their designee, to appeal my health plan on my behalf to provide the actions and the information necessary to overturn the denial or receive reimbursement for the underpaid claim. This authorization shall remain valid until the charges for the orders on this form are paid in full.

#### Authorization to Release Information and Pay Benefits

I authorize CGC Genetics to provide my insurance carrier all information, including test results, concerning my laboratory test(s). I understand I may be responsible for all charges not covered by my insurance carrier within sixty (60) days of claim submission. I authorize and direct that benefits under this claim be paid directly to CGC Genetics and I agree to remit CGC Genetics within thirty (30) days any payment for these services made directly to me. I acknowledge that the charges for the test(s) ordered by my physician will be withdrawn in the event of cancellation only if such cancellation is executed by the ordering physician and the copy of the written confirmation evidencing this action is provided to CGC Genetics prior to the insurance of the test result.

PATIENT SIGNATURE\* \_\_\_\_\_

### Pre-Payment • Option 2

Payment Type\* ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Card Number\* \_\_\_\_\_

Exp Date\* mm / yy \_\_\_\_\_ Cardholder Name\* \_\_\_\_\_

CVC/CVV\* \_\_\_\_\_ (3-4 digit code back of the card) Amount\* \$ \_\_\_\_\_

Date\* mm / dd / yy \_\_\_\_\_

#### Patient Acknowledgment

I hereby authorize the amount of the test to be paid directly to CGC genetics, Inc and authorize them to release medical information concerning my testing to my physician. I hereby acknowledge I am financially responsible for the entire amount(s) of the test(s).

SIGNATURE\* \_\_\_\_\_

## Physician ID

### Physician/Laboratory Contact Information

Contact Name First \_\_\_\_\_ Last \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

#### Tests ordered\*

Important: Write in the test code and the test name (see list on additional form)

Code \_\_\_\_\_ Name \_\_\_\_\_

Code \_\_\_\_\_ Name \_\_\_\_\_

ICD-9 Code\* \_\_\_\_\_

For BAbs/Nabs Testing, please provide IF-B start date: mm / dd / yy \_\_\_\_\_

#### Indications for testing (Check one)\*

☐ Diagnostic (symptomatic) ☐ Predictive (asymptomatic) ☐ Clinical Study

☐ Carrier ☐ Other Research

#### Testing Authorization

I warrant that this test was ordered and is either: 1) for the purpose of diagnosing or detecting an existing disease, illness, impairment, symptom or disorder, or 2) that if is not for such purpose, I have obtained the appropriate prior written consent. This written consent was signed by the person who is the subject of the test (or if that person lacks capacity to consent, signed by the person authorized to consent for that person), and includes: a) a statement of the purpose and description of the test; b) a statement that prior to signing the consent form, the consenting person discussed with the medical practitioner ordering the test the reliability of positive or negative test results and the level of certainty that a positive test result for that disease or condition serves as a predictor of such disease; c) a statement that the consenting person was informed about the availability and importance of further testing, physician consultation and genetic counseling, and provided with written information identifying a genetic counselor or medical geneticist from whom the consenting person might obtain such counseling; d) a general description of each specific disease or condition testing for; and e) the person or persons to whom the test results may be disclosed as indicated above.

MEDICAL PRACTITIONER SIGNATURE\* \_\_\_\_\_

### Required Physician Information

NPI#\* \_\_\_\_\_ UPIN#\* \_\_\_\_\_

Name\* First \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone #\* \_\_\_\_\_ ☐ Day ☐ Eve ☐ Cell Fax# \_\_\_\_\_

Email \_\_\_\_\_

### Additional Authorized Report Recipient

Name First \_\_\_\_\_ Last \_\_\_\_\_

UPIN# or CLIA# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone # \_\_\_\_\_ ☐ Day ☐ Eve ☐ Cell Fax# \_\_\_\_\_

Email \_\_\_\_\_

## Specimen Type

NOTE: Specimen tube(s) must be labeled with two of the following forms of identification: name, date of birth, social security no., patient ID no. These same two forms of ID should also be indicated on the test requisition.

☐ Blood (EDTA) ☐ Bone Marrow ☐ Other (specify): \_\_\_\_\_

Collection date: mm / dd / yy \_\_\_\_\_



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## TEST REQUEST\*

### CGC Mutation Panel® • PATENT PENDING •

#### 0010 Thrombophilia and Warfarin Pharmacogenetics

15 mutations on genes: APOE Cys112Arg, APOE Arg158Cys, EPCR 4678G/C, Factor V Leiden Arg506Gln, Factor II G20210A, MTHFR C677T, MTHFR A1298C, PAI-1 4G/5G, PAI-1 -844 A>G, ACE Ins/Del, Beta-Fibrinogen -455G>A, Factor XIII Val34Leu, CYP2C9 and VKORC1]

### NEW TESTS

#### Oncology

- ☐ 1251 Colorectal Cancer Screening (methylation analysis of SEPT9 gene)
- ☐ 1253 E-cadherin (sequence analysis)
- ☐ 1254 EGFR (sequence analysis)

### CYTOGENETICS

#### Hematology/Oncology

- ☐ 3051 Chromosome analysis of stimulated cultures (peripheral blood)
- ☐ 3052 Chromosome analysis of non-stimulated cultures (bone marrow and/or peripheral blood)
- ☐ 3054 Lymphocyte culture (bone marrow)

### MOLECULAR CYTOGENETICS

#### Hematology

- ☐ 3000 FISH analysis of sexual chromosomes (X/Y)
- ☐ 3001 FISH analysis with centromeric probe
- ☐ 3002 FISH analysis with painting probe
- ☐ 3003 FISH analysis with subtelomeric probe
- ☐ 3004 FISH analysis with unique sequence probe

#### Hematology/Oncology - Detection by FISH

- ☐ 3101 11q23 deletion
- ☐ 3102 13q14.3 deletion
- ☐ 3103 20q12 deletion
- ☐ 3104 5q31 deletion
- ☐ 3105 5q33-34 deletion
- ☐ 3106 6q21 deletion
- ☐ 3107 7q31 deletion
- ☐ 3108 9q34 deletion
- ☐ 3102 ALK rearrangements [del(2p); t(2;5)]
- ☐ 3110 ATM (11q22.3) rearrangements
- ☐ 3111 BCL-6 (3q27) rearrangements
- ☐ 3112 CBF8 rearrangements [(inv(16)/t(16;16)]
- ☐ 3113 Chromosome 6 aneuploidy
- ☐ 3114 Chromosome 9 aneuploidy
- ☐ 3115 Chromosome 8 trisomy
- ☐ 3116 Chromosome 12 trisomy
- ☐ 3117 c-MYC (8q24) rearrangements
- ☐ 3118 IGH (14q23) rearrangements
- ☐ 3119 MALT1 (18q21) rearrangements
- ☐ 3120 MLL (11q23) rearrangements
- ☐ 3121 OncoFish for CLL (13q-, 11q-, 17p-, +12, IGH)
- ☐ 3122 OncoFish for MDS (5q-, 7q-, 20q-)
- ☐ 3123 OncoFish for MM (13q-, 17p-, t(4;14), t(11;14))
- ☐ 3124 p16 (9p21) deletion
- ☐ 3125 PTEN (10q23) deletion
- ☐ 3126 RARα (17q21) rearrangements
- ☐ 3127 t(11;14) IGH/CCND1
- ☐ 3128 t(11;18) API2/MALT1
- ☐ 3129 t(12;21) ETV6/AML1
- ☐ 3130 t(14;16) IGH/MAF
- ☐ 3131 t(14;18) IGH/BCL2
- ☐ 3132 t(14;18) IGH/MALT1
- ☐ 3133 t(15;17) PML/RARα
- ☐ 3134 t(4;14) IGH/FGFR3
- ☐ 3135 t(8;14) MYC/IGH
- ☐ 3136 t(8;21) AML1/ETO1
- ☐ 3137 t(9;22) BCR/ABL

### MOLECULAR DIAGNOSTICS

#### Hematology

- ☐ 0451 Chimerism after bone marrow transplantation
- ☐ 0452 Drug metabolism (CYP2D6, CYP2C9, CYP2C19, CYP3A4 and NAT2 genes)
- ☐ 0453 Hereditary Hemochromatosis (frequent mutations of HFE gene)
- ☐ 0454 Thrombophilia marker Antithrombin III (sequence analysis of SERPINC1 gene)
- ☐ 0455 Thrombophilia marker APOE (alleles 2, 3 and 4)
- ☐ 0456 Thrombophilia marker Factor II (G20210A)
- ☐ 0457 Thrombophilia marker Factor V Leiden (R506Q)
- ☐ 0458 Thrombophilia marker FGB (-455G/A)
- ☐ 0459 Thrombophilia marker MTHFR (C677T and A1298C)
- ☐ 0460 Thrombophilia marker PAI-1 (4G/5G)
- ☐ 0461 Thrombophilia marker Protein C deficiency (sequence analysis of PROC gene)
- ☐ 0462 Thrombophilia marker Protein S deficiency (sequence analysis of PROS1 gene)
- ☐ 0010 Thrombophilia and Warfarin Pharmacogenetics see CGC Mutation Panel

#### Oncology

- ☐ 1252 Drug metabolism (CYP2D6, CYP2C9, CYP2C19, CYP3A4 and NAT2 genes)
- ☐ 1253 E-cadherin (sequence analysis)
- ☐ 1254 EGFR (sequence analysis)
- ☐ 1255 Familial Adenomatous Polyposis (APC gene)
- ☐ 1256 Familial Breast/Ovarian Cancer (deletion/duplication analysis of BRCA1 and BRCA2 genes)
- ☐ 1257 Familial Breast/Ovarian Cancer (sequence analysis of BRCA1 and BRCA2 genes)
- ☐ 1258 Gastric cancer (KRAS gene)
- ☐ 1259 Hepatic Adenoma (HNF1A gene)
- ☐ 1260 Hereditary Non-polyposis Colorectal Cancer, type 1 and 2, HNPCC (deletion/duplication analysis of MLH1 and MSH2 genes)
- ☐ 1261 Hereditary Non-polyposis Colorectal Cancer, type 1 and 2, HNPCC (sequence analysis of MLH1 and MSH2 genes)
- ☐ 1262 Hereditary Pancreatic Cancer (KRAS gene)
- ☐ 1263 Li-Fraumeni Syndrome (TP53 gene)
- ☐ 1264 Lung Cancer (tumor tissue, paraffin sections on EGFR3 gene)
- ☐ 1265 Microsatellite Instability in Colorectal Cancer
- ☐ 1266 Neurofibromatosis type I (deletion/duplication analysis of NF1 gene)
- ☐ 1267 Neurofibromatosis type I (NF1 gene)
- ☐ 1268 Neurofibromatosis type II (NF2 gene)
- ☐ 1269 Resistance to Imatinib (c-KIT)
- ☐ 1270 Resistance to Imatinib due to BCR/ABL mutations
- ☐ 1271 Resistance to Methotrexate (MTHFR)
- ☐ 1272 Resistance to Methotrexate (SLC19A1)
- ☐ 1273 Susceptibility to Cetuximab (KRAS)
- ☐ 1274 Susceptibility to Irinotecan (UGT1A1)
- ☐ 1275 Tamoxifen pharmacogenetics
- ☐ 1276 TP53 (sequence analysis)
- ☐ 1277 Von Hippel-Lindau Syndrome (deletions/duplications and mutations on VHL gene)
- ☐ 1278 Xenobiotics metabolism (GSTM1, GSTT1 and NAT2 genes)
- ☐ 0010 Thrombophilia and Warfarin Pharmacogenetics see CGC Mutation Panel

#### Hematology/Oncology

- ☐ 1401 AML1/ETO quantification
- ☐ 1402 B cells (IGH) clonal rearrangement
- ☐ 1403 BCR/ABL (p190) quantification
- ☐ 1404 BCR/ABL (p210) quantification
- ☐ 1405 Drug metabolism (CYP2D6, CYP2C9, CYP2C19, CYP3A4 and NAT2 genes)
- ☐ 1406 IGK clonal rearrangement
- ☐ 1407 JAK2 gene analysis (mutations on exon 12)
- ☐ 1408 JAK2 gene analysis (V617F mutation)
- ☐ 1409 JAK2 quantification
- ☐ 1410 Li-Fraumeni Syndrome (TP53 gene)
- ☐ 1411 MLP gene analysis (W515L/K mutations)
- ☐ 1412 PML/RARα quantification
- ☐ 1413 Resistance to Imatinib (c-KIT)
- ☐ 1414 Resistance to Imatinib due to BCR/ABL mutations
- ☐ 1415 Resistance to Methotrexate (SLC19A1 gene)
- ☐ 1416 Resistance to Methotrexate (MTHFR gene)
- ☐ 1417 t(11; 14) (IGH/BCL1) rearrangement
- ☐ 1418 t(14; 18) (IGH/BCL2) rearrangement

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## TEST REQUEST\*

- ☐ 1419 TCRB clonal rearrangement
- ☐ 1420 TCRG clonal rearrangement
- ☐ 1421 TEL/AML1 quantification
- ☐ 1422 TP53 (sequence analysis)
- ☐ 1423 WT1 quantification
- ☐ 1424 Xenobiotics metabolism (GSTM1, GSTT1 and NAT2 genes)

| Type of Analysis                          | Type of Sample  | Amount               |
|---|---|----------------------|
| CGC Mutation Panel                        | DNA   | 500 ng               |
|   | Peripheral Blood – L  | 3-5 mL               |
| Molecular Diagnosis                       | DNA   | 500 ng               |
|   | Peripheral Blood – L  | 3-5 mL               |
| Molecular Diagnosis (prenatal testing)    | DNA from fetus + DNA from mother  | 500 ng               |
|   | RNA   | 1000 ng              |
| Molecular Diagnosis (expression analysis) | Peripheral Blood (PAX gene tubes)   | 3 mL                 |
|   | Non stained cytogenetics slides   | 3 slides per culture |
| Cytogenetics Analysis                     | Fixed cell suspension   | 1 tube per culture   |
|   | Peripheral Blood (green top tube with Sodium Heparin) (for conventional karyotyping and FISH) | 3-5 mL               |

**Shipping:** Send specimen overnight at room temperature (must arrive less than 24 hrs after collection). Ship **Monday through Thursday** only.

**Tube Type:** L - Lavender top tube with EDTA

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