EXPRESS GENE MOLECULAR DIAGNOSTICS LABORATORY

GENETIC TEST REQUISITION FORM

9000 SW 152 Street Ste. 209
Miami • FL • 33157
Tel: 786.250.3419 • Fax: 786.250.3074
Email: info@expressgene.us

Patient Information

First Name: | Last Name:

DOB | SEX: M ☐ F ☐

Ethnicity:

☐ African ☐ European (Finnish) ☐ Latino
☐ Ashkenazi Jewish ☐ East Asian ☐ South Asian
☐ European (Non-Finnish) ☐ Near/Middle Eastern ☐ Other

Street Address:

City/State/Zip: | Phone:

Email: | MRN:

Ordering Physician Information

First Name: | Last Name:

Institution/Practice Name: | NPI#:

Street Address:

City/State/Zip: | Phone:

Email: | Fax:

Additional Copy of Results (If applicable)

Name:

Email: | Fax:

Confirmation of Informed Consent and Medical Necessity for Genetic Testing

My signature below certifies that I am a licensed medical professional or his/her representative or a genetic counselor authorized to order genetic testing. My signature further acknowledges the patient has been supplied information regarding genetic testing and has been informed about the purpose, limitations and possible risks. The patient has been given the opportunity to ask questions about this consent and seek outside genetic counseling. The patient has given consent for genetic testing to be performed and the signed consent form is on file.

I confirm that this testing is medically necessary for the specified patient, and that these results will be used in the medical management and treatment decisions for this patient.

I confirm that the patient has been informed and hereby authorizes (i) Express Gene Molecular Diagnostics to release information concerning their testing to their insurer in order to obtain reimbursement for the testing services; (ii) Express Gene Molecular Diagnostics to be paid directly by the insurer for services rendered; and/or if applicable (iii) Express Gene Molecular Diagnostics or its affiliates to be the patient's designated representative for the purpose of appealing any denial of insurance benefits. I confirm the patient fully understands they are legally responsible for sending Express Gene Molecular Diagnostics any and all of the money that they receive directly from their insurance company in payment for this testing.

Medical Professional Signature _____ Date _____

Tests Ordered

☐ Clinical Whole Exome Sequencing (WES)*

Exonic regions in more than 18,000 Protein-Coding Genes*:

Sample Information: ☐ Buccal Smear ☐ Blood

Other Specify Blood

* For further details, please visit **expressgene.us**

Clinical Information

ICD 10 code(s): _____

List Relevant family history of disease:

Date of Collection: (MM/DD/YYYY) _____

Payment Information

INSURANCE BILL (Please include a copy of the front and back of the patient's insurance card)

Insurance Company | Policy # | Group#

Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other Name and DOB of Policy Holder (if not self) _____

By signing this form, I hereby authorize Express Gene Molecular Diagnostics to submit the medical information regarding this testing to my designated insurance carrier for reimbursement if necessary. I also authorize benefits to be payable to Express Gene Molecular Diagnostics.

I understand that I am responsible for any amounts not paid by insurance for reasons, but not limited to non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

Patient Signature _____ Date: _____

INSTITUTIONAL BILL

Institution Name: | Billing contact name:

Address:

City/State/Zip: | Phone:

Email: | Fax:

PATIENT BILL ☐ Credit card

Amount: $ ☐ Send an invoice to the patient address provided

☐ Payment plan desired (contact Express Gene)

Card Type: ☐ VISA ☐ Mastercard ☐ Discover ☐ AMEX

Name as it appears on card:

Card # | CVC# | EXP Date

I authorize Express Gene Molecular Diagnostics to charge my credit card the amount listed above.

Signature: Date: