Hereditary Cancer Panels Requisition

Phone 866.776.5907 / Fax 239.690.4237
neogenomics.com

Client Information

Required Information

Account #: _____ **Account Name:** _____

Street Address: _____

_____

City, ST, ZIP: _____

Phone: _____ **Fax:** _____

Requisition Completed by: _____ Date: _____

Ordering Physician (please print: Last, First): _____ NPI #: _____

Treating Physician (please print: Last, First): _____ NPI #: _____

The undersigned certifies that he/she is licensed to order the test(s) listed below and that such test(s) are medically necessary for the care/treatment of this patient.

Authorized Signature: _____ Date: _____

Billing Information

Required: Please include face sheet and front/back of patient's insurance card.

Patient Status (Must Choose 1): ☐ Hospital Patient (in) ☐ Hospital Patient (out) ☐ Non-Hospital Patient

Bill to: ☐ Client Bill ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Patient/Self-Pay

☐ Split Billing - Client (TC) and Insurance (PC) ☐ OP Molecular to MCR, all other testing to Client

☐ Bill charges to other Hospital/Facility: _____

Prior Authorization # _____ See the NeoGenomics.com Billing section for more info.

Clinical Information

Required: Please attach patient's pathology report, clinical history, and other applicable report(s).

ICD 10 (Diagnosis) Code/Narrative (Required): _____

Reason for Referral: _____

Has patient had transfusion in last 2 weeks, or stem cell transplant at any time? ☐ Y ☐ N

Patient Information

Last Name: _____ ☐ **Male** ☐ **Female**

First Name: _____ **M.I.** _____ Other Pt ID/Acct #: _____

Date of Birth: mm _____ / dd _____ / yyyy _____ Medical Record #: _____

Client represents it has obtained informed consent from patient to perform the services described herein.

Reason for Referral:

☐ Patient History of Cancer ☐ Family History of Cancer

☐ Other: _____

Specimen Information

Specimen ID: _____ **Block ID:** _____

Collection Date: mm _____ / dd _____ / yyyy _____ **Collection Time:** _____ ☐ AM ☐ PM

Retrieved Date: mm _____ / dd _____ / yyyy _____

Hospital Discharge Date: mm _____ / dd _____ / yyyy _____

☐ Peripheral Blood: Green Top(s) _____ Purple Top(s) _____ Other _____

Comments

Patient Clinical Data

Race/Ethnicity - Please check all that apply

☐ African American/Black
☐ Hispanic
☐ Eastern/Central European
☐ Asian
☐ Jewish (Ashkenazi)
☐ Western/Northern European
☐ Middle Eastern
☐ Native American
☐ Other: _____

Patient history of cancer - Check sites and fill in age of diagnosis

☐ Breast
- ☐ Right _____ ☐ Left _____
- ☐ Other (explain): _____

☐ Colorectal
- ☐ Right Colon _____ ☐ Left Colon _____
- ☐ Transverse Colon _____ ☐ Rectum _____
- ☐ Other (explain): _____

☐ Other Cancer (explain): _____

☐ Mismatch Repair (MMR) IHC Results: _____

Family history of cancer - Relationship, sites

_____

_____

Has the patient ever had a germline BRCA1/2 test before? ☐ Yes ☐ No

Note: If done previously, a patient will likely be responsible for full payment.

Hereditary Cancer Tests

☐ **Bone Marrow Failure NGS Panel** (60 genes)
☐ **BRCA1/2 Focus Panel** (Germline)
☐ **BRCA1 Single Gene** (Germline)
☐ **BRCA2 Single Gene** (Germline)
☐ **Colorectal Cancer Focus Panel** (Germline) (18 genes)
☐ **Full Comprehensive Cancer Panel** (Germline) (127 genes)
☐ **Full Focus Cancer Panel** (Germline) (30 genes)

Testing performed by Fulgent Genetics.

Informed Consent REQUIRED

A signed Fulgent Genetics Informed Consent for Genetic Testing form is required. See test in NeoGenomics' Test Directory at www.neogenomics.com to download form and please submit it with sample.

Testing may be delayed until signed consent is received.

Specimen Requirements

Refrigerate specimen if not shipping immediately and use cool pack during transport. Please call Client Services Team with any questions regarding specimen requirements or shipping instructions at 866.776.5907 option 1. Please refer to the website for specific details on each specimen.

Additional Billing Information

Any organization referring specimens for testing services pursuant to this Requisition Form ("Client") expressly agrees to the following terms and conditions.

1. **Binding Service Order.** This Requisition Form is a legally binding order for the services ordered hereunder ("Services") and Client agrees that it is financially responsible for all tests billable to Client hereunder.

2. **Third Party Billing by NeoGenomics and Right to Bill Client.** Client agrees to accurately indicate on the front of the Requisition Form that either Client should be billed (e.g., Client receives reimbursement pursuant to a non-fee-for-service basis, including, but not limited to, a capitated, diagnostic related group ("DRG"), per diem, all-inclusive, or other such bundled or consolidated billing arrangement) or NeoGenomics should bill the applicable federal, state or commercial health insurer or other third party payer (collectively, "Payers") for all Services ordered pursuant to this Requisition Form. For all such Services billable to Payers, Client agrees to provide all billing information necessary for NeoGenomics to bill such payer. In the event NeoGenomics: (i) does not receive the billing information required for it to bill any Payers within ten days of the date that any Services are reported by NeoGenomics; (ii) the Services were performed for patients who have no Payer coverage arrangements; or (iii) the Payer identified by Client denies financial responsibility for the Services and indicates that Client is financially responsible, NeoGenomics shall have the right to bill such Services to Client.

Test Descriptions

Please see complete test descriptions and all available tests at our website, www.neogenomics.com.

CORP-MRKT-0026 Rev. 101620