Advanced Diagnostics Laboratory LLC
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INSURANCE ORDERING CHECKLIST

- ☐ List of Current Medications
- ☐ ICD-10 Code(s)
- ☐ Physician & Patient Signatures
- ☐ Copy of Patient Insurance Card

PHARMACOGENETIC TEST REQUISITION

PATIENT INFORMATION

Name (Last, First, MI): _____

Address: _____

City, State, Zip: _____

DOB (MM/DD/YY): _____ Gender: ☐ M ☐ F

Patient ID # (optional): _____

ORDERING PROVIDER INFORMATION

Provider Name: _____

Practice / Facility Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

SPECIMEN INFORMATION

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

Time of Collection: _____

Specimen Type: ☑ Buccal Swab

BILLING INFORMATION

(Please provide a legible photocopy of the front & back of the patient's insurance card)

Name of Insured: _____
Relation to Patient: _____
Member Group #: _____
Member Policy #: _____
ICD10 DX Code(s): _____

ORDER TESTS

(Please list any special instructions for the individual patient below.)

☐ **Pharmacogenomics Panel** ATM, COMT, CYP1A2, CYP2B6, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, DPYD, F2, F5, GRIK4, IFNL4, MTHFR, OPRM1, RYR1, SLCO1B1, TPMT, UGT1A1, VKORC1, LDLR, APOB, HFE, AGTR1, CYP2C8, APOE, HTR2A, HTRC2

☐ **Additional Notes / Special Instructions:**

Renal Function: ☐ 1 ☐ .8 ☐ .6 ☐ .4 ☐ .2

Smoker? ☐ Yes ☐ No

PRESCRIBED MEDICATIONS

Please list all current medications or select from the list on the back of this form. Please attach additional sheets as necessary:

_____

_____

_____

_____

STOP PATIENT SIGN HERE

Patient Acknowledgement: *I acknowledge that the information provided by me for this genetic test is true and accurate. I hereby authorize Advanced Diagnostics Laboratory LLC to release the results of this testing to the treating physician or facility. I hereby assign all rights and benefits under my health plan and direct payments be made to Advanced Diagnostics Laboratory LLC or its assigned affiliates for laboratory services furnished to me by Advanced Diagnostics Laboratory LLC. I irrevocably designate, authorize and appoint Advanced Diagnostics Laboratory LLC or its assigned affiliates as my true and lawful attorney-in-fact for the purpose of submitting my claims and pursuing any request, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with any federal or state laws. If my health plan fails to abide by my authorization and makes payment directly to me, I agree to endorse the insurance check and forward it to Advanced Diagnostics Laboratory LLC immediately upon receipt. I hereby authorize Advanced Diagnostics Laboratory LLC or its assigned affiliates to contact me for billing or payment purposes by phone, text message, or email with the contact information that I have provided to Advanced Diagnostics Laboratory LLC , in compliance with federal and state laws.*

Signature of Patient or Patient Representative / Relationship to Patient _____ Date _____

STOP ORDERING PHYSICIAN SIGN HERE

Physician must only order tests that are medically necessary for the diagnosis or treatment of a patient.

Ordering Physician Signature _____ Date _____