Advanced Diagnostics Laboratory LLC
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INSURANCE ORDERING CHECKLIST
- ☐ Clinic Note(s) and Pedigree
- ☐ ICD-10 Code(s)
- ☐ Physician & Patient Signatures
- ☐ Copy of Patient Insurance Card
- ☐ Completed Patient Questionnaire

Hereditary Cancer Test Requisition (Blue Sections Required)

PATIENT INFORMATION

Last Name	First Name	Middle Initial	DOB (MM/DD/YY)	Date of Discharge (if applicable)

Street Address	City	State/Country	Zip

Preferred Contact Phone Number	Biological Sex: ☐ F ☐ M Gender Identity (if different from marked): _____	Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Jewish (Ashkenazi) ☐ Portuguese ☐ Other: _____

SPECIMEN INFORMATION

Type(s) ☐ Buccal swabs	Date Collected:	Time Collected:

SENDING FACILITY Facility Type: ☐ Physician/Physician Group ☐ Referral Lab ☐ Hospital

Facility Name	Address	Phone	Fax	Email

ORDERING PHYSICIAN AND/OR OTHER LICENSED MEDICAL PROFESSIONAL

Name (Last, First, Degree) (Clinician Code)	Phone	Fax	Email	NPI#

ADDITIONAL RESULTS RECIPIENTS

☐ Primary Contact	Medical Professional Name (Clinician Code)	Phone	E-mail or Fax
☐ Primary Contact	Genetic Counselor Name (Clinician Code)	Phone	E-mail or Fax

CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY FOR GENETIC TESTING

By ordering testing, the undersigned person represents that he/she is a licensed medical professional authorized to order genetic testing OR is a representative of a licensed medical professional authorized to order genetic testing; acknowledges the patient has been supplied information regarding genetic testing and the patient has given consent for genetic testing to be performed and the signed consent form is on file. I confirm that this is medically necessary for the diagnosis or detection of a disease, illness, impairment, syndrome or disorder, and that these results will be used in the medical management and treatment decisions for this patient. Furthermore, additional results recipients information is true and correct to the best of my knowledge.

My signature here applies to the attached letter of medical necessity (if applicable). If you do not want your signature on this TRF to apply to the attached LMN, please provide an LMN and/or Clinical Notes with your order and check here. ☐

Does this patient give consent to the use of their sample for research? ☐ Yes ☐ No

Medical Professional Signature:_____ Date: _____

☐ INSURANCE BILLING (include copy of both sides of insurance card)

Patient Relation to Policy Holder? ☐ Self ☐ Spouse ☐ Child	Name and DOB of Policy Holder (if not self)	
Insurance Company	Policy #	HMO Authorization #

☐ PATIENT PAYMENT

☐ Check ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Card Number	Exp. Date	CVC #

Cardholder Name	Amount $

☐ INSTITUTIONAL BILLING

Facility Name	
Street Address	
City	
State	Zip Code
Contact Name	
Phone Number	E-mail

Billing ABN and Patient Protection Plan Information:
A completed Advance Beneficiary Notice (ABN) of coverage is required for Medicare patients who do not meet medical criteria for testing. Billing laboratory preverifies insurance coverage and will contact the patient after the patient's sample is received if the out-of-pocket amount for testing is estimated to exceed $100. Insurance pre-verification will not be performed for specific site analyses, unless specifically requested. All tests ordered with a bill type of insurance shall be processed and billed based on payor criteria.

Patient Acknowledgement: I acknowledge that the information provided by me is true to the best of my knowledge. For direct insurance/3rd party billing: I hereby authorize my insurance benefits to be paid directly to Advanced Diagnostics Laboratory LLC and authorize them to release medical information concerning my testing to my insurer. If applicable, I authorize Advanced Diagnostics Laboratory LLC to be my Designated Representative for purposes of appealing any denial of benefits. I acknowledge and agree that Advanced Diagnostics Laboratory LLC has the right to request additional medical records, such as consult notes, pedigrees, and clinical/family history notes directly from my provider(s) for the purpose of insurance verification and proper billing. I also fully understand that I am legally responsible for sending **Advanced Diagnostics Laboratory LLC** any money received from my health insurance company for performance of this genetic test. For patient payment by credit card: I hereby authorize Advanced Diagnostics Laboratory LLC to bill my credit card as indicated above.

Patient Signature: _____ Date: _____

Hereditary Cancer Test Requisition

Patient Name: _____ DOB: _____

INDICATIONS FOR TESTING (CHECK ALL THAT APPLY)

☐ Diagnostic (history of cancer or polyps) ☐ Family history of cancer ☐ Positive or normal control ☐ Other_____

ICD-10 code(s): _____

☐ Test results will affect immediate medical management, date results needed (if known): _____

PATIENT CLINICAL HISTORY ☐ no personal history of cancer

Cancer/Tumor	Age at Dx	Pathology and Other Info
Breast		Type: ER☐(+) ☐(-) ☐unk PR☐(+) ☐(-) ☐unk HER2/neu☐(+) ☐(-) ☐unk
2nd primary breast		Type: ER☐(+) ☐(-) ☐unk PR☐(+) ☐(-) ☐unk HER2/neu☐(+) ☐(-) ☐unk
Ovarian		☐ Fallopian tube ☐ Primary peritoneal
Prostate		Gleason score:
Hematologic		Type: ☐ Allogenic bone marrow or peripheral stem cell transplant
Other cancer		Type:

Other clinical history:

PATIENT TESTING HISTORY (PLEASE INCLUDE COPIES OF ANY PREVIOUS TEST RESULTS) ☐ No previous molecular and/or genetic testing

☐ Germline genetic testing Test(s) performed: _____ Result(s): _____

☐ Somatic test/tumor profile Test(s) performed: _____ Result(s): _____

FAMILY HISTORY* ☐ None (maternal) ☐ None (paternal) ☐ Maternal hx unknown ☐ Paternal hx unknown

*Completing this section is not mandatory for ordering if a pedigree and/or clinical note with family history is supplied, but is recommended and helps with results interpretation and claims filing.

Relation to patient	Maternal	Paternal	Cancer Type	Dx age	Relation to patient	Maternal	Paternal	Cancer Type	Dx age
	☐	☐				☐	☐		
	☐	☐				☐	☐		
	☐	☐				☐	☐		
	☐	☐				☐	☐		

TESTS REQUESTED

(Physicians must only order tests that are medically necessary for the diagnosis or treatment of the patient. The following panel(s) may be changed by the provider, on a case-by-case basis, by making their testing preferences clear in the space provided below)

☐ Comprehensive Hereditary Cancer Panel (37 Genes)

APC, ATM, BLM, BRCA1, BRCA2, CDH1, CDKN2A, FANCC, FH, HNF1A, HRAS, KIT, MEN1, MLH1, MSH2, MSH6, MUTYH, NF1, NF2, NSD1, PALB2, PHOX2B, PMS2, PTEN, RET, RUNX1, SDHA, SDHB, SDHC, SDHD, SMAD4, STK11, TP53, TSC1, TSC2, VHL, WT1

NOTES / INDIVIDUAL GENES / ADDITIONAL INSTRUCTIONS:

*Please make sure to indicate ethnicity on page 1.

Hereditary Cancer Patient Questionnaire

Please read and answer the questions below. While answering, consider relatives who are living along with those who have passed away, those who are sick and those in remission, male and female relatives, and relatives on both your mother and father's side of the family. "Relatives" refer to blood relatives and include: mother, father, son daughter, brother, sister, half-brother, half-sister, uncle, aunt, nephew, niece, grandparent, grandchild, cousin.

1. Have YOU ever been diagnosed with any of these cancers prior to the age listed?

[ ] BREAST CANCER (age 45 or younger)
[ ] COLON CANCER (age 50 or younger)
[ ] ENDOMETRIAL/UTERINE CANCER (age 50 or younger)
[ ] OVARIAN CANCER (any age)

2. Have YOU ever been diagnosed with either PROSTATE or PANCREATIC cancer? [ ] YES [ ] NO

IF YES: Do you also have ONE or more relatives diagnosed with any of these cancers?

[ ] PROSTATE CANCER [ ] PANCREATIC CANCER [ ] BREAST CANCER (age 50 or younger)

3. Have YOU ever been diagnosed with BREAST cancer between ages 46-50? [ ] YES [ ] NO

IF YES: Do you also have any of the following?

[ ] ONE or more relatives diagnosed with BREAST CANCER, PANCREATIC CANCER or PROSTATE CANCER (at ANY AGE)
[ ] TWO or more relatives on the same side of the family diagnosed with BREAST CANCER at ANY AGE?

4. Have YOU been diagnosed with BREAST cancer at any age? [ ] YES [ ] NO

IF YES: Do you also have any of the following?

[ ] ONE or more relatives diagnosed with BREAST CANCER at age 50 or under?
[ ] TWO or more relatives on the same side of the family diagnosed with BREAST CANCER at ANY AGE?

5. Have any relatives been diagnosed with BREAST (age 45 and under) or OVARIAN cancer (any age)? [ ] YES [ ] NO

6. Do you have ONE relative that was diagnosed with BREAST cancer (any age)? [ ] YES [ ] NO

IF YES:Do you also have any of the following on the same side of the family?

[ ] ONE or more additional relatives diagnosed with BREAST CANCER at age 50 or younger
[ ] TWO or more relatives diagnosed with BREAST CANCER at ANY AGE?

7. Do you have ONE relative that was diagnosed with PANCREATIC OR PROSTATE cancer? [ ] YES [ ] NO

IF YES: Do you also have ONE or more additional relatives on the same side of your family diagnosed with any of these cancers?

[ ] PROSTATE CANCER
[ ] PANCREATIC CANCER
[ ] BREAST CANCER (age 50 or younger)

8. Do you have ONE Relative that was diagnosed with COLORECTAL or ENDOMETRIAL cancer? [ ] YES [ ] NO

IF YES:

[ ] Do you also have ONE or more additional relatives on the same side of your family diagnosed at age 50 or younger with any of these cancers: COLORECTAL or ENDOMETRIAL
[ ] Do you also have TWO or more additional relatives on the same side of your family diagnosed with any of these Cancers at any age?

COLORECTAL, ENDOMETRIAL, PANCREATIC, SMALL BOWEL, HEPATOBILIARY TRACT, LIVER, URINARY TRACT, RENAL PELVIS, URETER, OVARIAN, BRAIN or STOMACH

Answering these questions does not guarantee that your insurance will cover a cancer screening. The screening is a predictive test that can identify if you are at increased risk for certain types of cancer. It does not diagnose cancer or determine definitively if you will develop cancerin your lifetime.