

Athena Diagnostics Endocrinology Patient Insurance Test Requisition (January 2017)

Patients Requesting Financial Assistance - Patients who meet certain income guidelines may qualify for financial assistance. Please complete the patient identification information and Athena Diagnostics® will contact the patient directly to initiate the application process and (for patients where insurance remits to patient only) to collect prepayment.

Many payers (including Medicare and Medicaid) have medical necessity requirements. You should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

NOTE: Client services is now available until 9:00 PM ET. They can be reached at 800-394-4493, option 2.



Fields in red indicate required information

Please tear at perforation

Patient

Insured Patient Information

Complete this requisition for all patients with insurance, including Medicare. Patients with an insurance plan for which Athena Diagnostics is a contracted provider are subject to any co-insurance and deductible of their plan. Athena Diagnostics will bill the patient's insurance for the total price of the test and work on the patient's behalf to file appropriate justifications and/or appeals when applicable. Patients should verify coverage with their health plan prior to testing.

Patient Identification

Patient Name _____
First Last

Patient ID # (if available) _____

DOB _____ Sex: Male Female

Last Four Digits of SS# _____ Unknown

Mailing Address _____

City _____ State _____ Zip _____

Phone #1 _____ Day Eve Cell

Phone #2 _____ Day Eve Cell

Patient Email _____

Appeal Authorization: In the event of an underpayment or denial by my insurance carrier, I hereby authorize Athena Diagnostics or their designee to appeal to my insurance carrier on my behalf, to provide the actions and 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 Athena Diagnostics to provide my insurance carrier all information, including test results, concerning my laboratory test(s). I understand that I may be responsible for all charges not covered by my insurance carrier, and I understand that payment is due within thirty (30) days of receipt of your invoice. I authorize and direct that benefits under this claim be paid directly to Athena Diagnostics, and I agree to remit to Athena immediately 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 a copy of the written confirmation evidencing this action is provided to Athena prior to the issuance of the test result.

1. Athena Diagnostics and/or designee may perform this appeal on my behalf, but is not obligated to do so.

Patient Signature _____ Date _____

Authorization to Use De-identified Specimen for Research. To promote medical understanding and develop better health insights, Athena Diagnostics requests your permission to use your specimen in a de-identified way (without identifying information) for research, if appropriate. Your name or other personal identifying information will not be used in or linked to the results of any studies and publications. Your refusal to have your specimen used or not used for research purposes will not affect processing or testing of your specimen, your test results or the service support provided by Athena Diagnostics to your physician. Please indicate your approval by checking the box next to **Yes** or denial by checking the box next to **No**.

I consent to the use of my de-identified specimen for research: Yes No

Signature of Patient, Parent or Legally Authorized Representative _____ Date _____

Printed Name of Patient, Parent or Legally Authorized Representative _____ Date _____

Relationship to Patient if Signatory is Someone Other than Patient _____

Patient Insurance Information

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

Insurance Co. Name _____

Member ID # _____

Group ID # _____

Address _____

City _____ State _____ Zip _____

Phone _____

Does the patient have secondary insurance? Yes No

If yes, please attach face sheet and copy of front and back of insurance card.

Physician

Physician/Laboratory Contact Information

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

Contact Name _____
First Last

Phone _____ Fax _____

Email _____

Tests Ordered

Important: Write in the test code and test name (see list on reverse).

Code _____ Name _____

Code _____ Name _____

ICD Code (Required): _____

Required Physician Information

NPI # _____

Athena Account # (if assigned) _____

Name _____
First Last

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Additional Authorized Result Report Recipient

Name _____
First Last

UPIN # or CLIA # _____

Address _____
(P.O. Box not acceptable)

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Indications for Genetic Testing (Check One)

Diagnostic (symptomatic) Prenatal Family Testing

Predictive (asymptomatic) Carrier

Physician Attestation of Informed Consent

In accordance with Massachusetts General Law Chapter 111, Section 70G, and New York Civil Rights Law Section 79-1 verification of patient informed consent is required for genetic testing. Additionally, testing laboratories located in Massachusetts require a signed acknowledgement from the ordering medical practitioner. The signed acknowledgement is required to complete the genetic testing ordered if you have not previously signed a blanket Physician Attestation of Informed Consent (PAIC) at any Quest lab. The company offers a blanket PAIC that can be signed for all future orders.

I warrant that I have obtained both oral and written consent using the **Patient Informed Consent Form for Genetic Testing** provided by Athena Diagnostics. 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).

Medical Practitioner Signature _____ Date _____

Printed Name of Medical Practitioner _____ NPI _____

Patient Informed Consent Form for Genetic Testing is available at AthenaDiagnostics.com/consent.

Type of Specimen Whole Blood CVS: Cultured Amniotic Fluid: Cultured **Date Collected*** _____

NOTE: Specimen tube(s) must be labeled with two of the following forms of identification: name, date of birth, last four digits of SS#, patient ID no. These same two forms of ID must be indicated on the test requisition. Reflex testing will be performed at an additional charge.

For Specimen Collection Service,* Please Fax this Test Requisition to 610-271-6085.

*Specimen collection service will work with the patient to obtain phlebotomy services through either a home draw or other laboratory. See online catalog at AthenaDiagnostics.com for complete specifications and shipping information.

Note: Test requisitions become outdated. For the most accurate and up-to-date test offering, please visit AthenaDiagnostics.com.

STOP
Signature
Required
Here

Endocrinology Patient Insurance Test Requisition (January 2017)



Test Code	Test Name	Genes Included
Adrenal Disorders		
<input type="checkbox"/> 816	Primary Adrenal Insufficiency Evaluation	ABCD1, NROB1, AIRE
	<input type="checkbox"/> 812 Autoimmune Polyglandular Syndrome (AIRE) Evaluation	
	<input type="checkbox"/> 815 ABCD1 (Adrenoleukodystrophy) DNA Sequencing Test	
	<input type="checkbox"/> 814 NROB1 (Adrenal Hypoplasia Congenita) DNA Sequencing Test	
<input type="checkbox"/> 881	Endocrine Hypertension (HSD11B2) Evaluation	
<input type="checkbox"/> 855	PHEX (Hypophosphatemic Rickets) DNA Sequencing Test	
<input type="checkbox"/> 856	FGF23 (Hypophosphatemic Rickets) DNA Sequencing Test	
<input type="checkbox"/> 879	Congenital Adrenal Hyperplasia (CAH) Evaluation	CYP21A2 sequencing and deletion, CYP11B1 sequencing
	<input type="checkbox"/> 880 CYP21A2 (CAH) Evaluation	
	Required: Indication for Study (check one or more below):	
	<input type="checkbox"/> Family history of CAH	
	<input type="checkbox"/> Virilization (ambiguous genitalia)	
	<input type="checkbox"/> Salt Wasting	
	<input type="checkbox"/> Parent/sibling of CAH patient	
	<input type="checkbox"/> 17-hydroxyprogesterone (17-OHP) elevated concentration in serum	
	<input type="checkbox"/> Other _____	
	<input type="checkbox"/> 875 CYP11B1 (CAH) DNA Sequencing Test	
<input type="checkbox"/> 874	Lipoid CAH (STAR) DNA Sequencing Test	
<input type="checkbox"/> 877	CYP17A1 DNA Sequencing Test	
<input type="checkbox"/> 878	HSD3B2 DNA Sequencing Test	
<input type="checkbox"/> 881	Endocrine Hypertension (HSD11B2) Evaluation	
Bone Diseases		
<input type="checkbox"/> 860	Osteogenesis Imperfecta Evaluation	COL1A1, COL1A2
	<input type="checkbox"/> 861 COL1A1 (OI) DNA Sequencing Test	
	<input type="checkbox"/> 862 COL1A2 (OI) DNA Sequencing Test	
<input type="checkbox"/> 811	LRP5 (OPPG) DNA Sequencing Test	
<input type="checkbox"/> 821	LRP5 Idiopathic Osteoporosis (IOP) DNA Sequencing Test	
<input type="checkbox"/> 857	Hypophosphatemic Rickets Evaluation	PHEX, FGF23
	<input type="checkbox"/> 855 PHEX (Hypophosphatemic Rickets) DNA Sequencing Test	
	<input type="checkbox"/> 856 FGF23 (Hypophosphatemic Rickets) DNA Sequencing Test	
Congenital Hyperinsulinism		
<input type="checkbox"/> 819	Congenital Hyperinsulinism Evaluation	GLUD1, GCK, KCNJ11, ABCC8
	Indication for Study (check one or more below):	
	<input type="checkbox"/> Diazoxide Responsive	
	<input type="checkbox"/> Diazoxide Non-Responsive	
	<input type="checkbox"/> Hypoglycemic	
	<input type="checkbox"/> Large for Gestational Age (LGA)	
	<input type="checkbox"/> Other (describe) _____	
	<input type="checkbox"/> 822 GLUD1 (CHI) DNA Sequencing Test	
	<input type="checkbox"/> 823 GCK (CHI) DNA Sequencing Test	
	<input type="checkbox"/> 826 KCNJ11 (CHI) DNA Sequencing Test	
	<input type="checkbox"/> 827 ABCC8 (CHI) DNA Sequencing Test	
<input type="checkbox"/> 42	CH Parental Testing – To augment child/proband diagnosis	
	For expedited diagnosis of proband, send parental testing samples as soon as possible and provide information below.	
	<input type="checkbox"/> Mother <input type="checkbox"/> Father	
	Proband Name/Accession # _____	

Test Code	Test Name	Genes Included
Diabetes		
<input type="checkbox"/> 8800	Monogenic Diabetes (MODY) Four-Gene Evaluation	HNFI1A, GCK, HNF4A, HNF1B
<input type="checkbox"/> 8801	Monogenic Diabetes (MODY) Three-Gene Evaluation	HNFI1A, GCK, HNF1B
<input type="checkbox"/> 8802	Monogenic Diabetes (MODY) Two-Gene Evaluation	HNFI1A, GCK
<input type="checkbox"/> 885	Monogenic Diabetes (MODY) Five-Gene Evaluation	HNFI1A, GCK, HNF4A, HNF1B, IPF1
	<input type="checkbox"/> 802 HNF4A (MODY1) DNA Sequencing and Deletion Test	
	<input type="checkbox"/> 803 GCK (MODY2) DNA Sequencing and Deletion Test	
	<input type="checkbox"/> 804 TCF1 (MODY3) DNA Sequencing and Deletion Test	
	<input type="checkbox"/> 834 IPF1 (MODY4) DNA Sequencing Test	
	<input type="checkbox"/> 805 TCF2 (MODY5) DNA Sequencing and Deletion Test	
<input type="checkbox"/> 837	CEL (MODY8) Mutation Analysis	
<input type="checkbox"/> 882	Neonatal Diabetes Mellitus Evaluation	IPF1, GCK, KCNJ11, INS, ABCC8
	<input type="checkbox"/> 841 IPF1 (NDM) DNA Sequencing Test	
	<input type="checkbox"/> 842 GCK (NDM) DNA Sequencing Test	
	<input type="checkbox"/> 843 KCNJ11 (NDM) DNA Sequencing Test	
	<input type="checkbox"/> 853 INS (NDM) DNA Sequencing Test	
	<input type="checkbox"/> 876 ABCC8 (NDM) DNA Sequencing Test	
Nephrogenic Diabetes		
<input type="checkbox"/> 854	Nephrogenic Diabetes Insipidus Evaluation	AVPR2, AQP2
	<input type="checkbox"/> 851 Nephrogenic Diabetes Insipidus (AVPR2) DNA Sequencing Test	
	<input type="checkbox"/> 852 AQP2 (Nephrogenic Diabetes Insipidus) DNA Sequencing Test	
Familial Cancer Syndromes		
<input type="checkbox"/> 818	MEN1 DNA Sequencing Test	
<input type="checkbox"/> 889	Pheochromocytoma Evaluation	RET, VHL, SDHB
	<input type="checkbox"/> 813 MEN2 (RET) DNA Sequencing Test	
	<input type="checkbox"/> 858 von Hippel-Lindau Syndrome (VHL) DNA Sequencing Test	
	<input type="checkbox"/> 888 SDHB DNA Sequencing Test	
Familial Hypocalciuric Hypercalcemia		
<input type="checkbox"/> 829	Familial Hypocalciuric Hypercalcemia (CASR) DNA Sequencing Test	
Familial Testing – Targeted Analysis		
<input type="checkbox"/> 185	Familial DNA Sequence Evaluation	
	This test detects previously identified sequence variants in at-risk family members. This test is available for HNF4A, GCK, TCF1, IPF1, TCF2, COL1A1, COL1A2, MEN1, and RET mutations	
	Proband Accession # _____	Relationship _____
Lipid Disorders		
<input type="checkbox"/> 895	Hypercholesterolemia Evaluation	LDLR, APOB
	<input type="checkbox"/> 894 LDLR (Hypercholesterolemia) DNA Sequencing Test	
	<input type="checkbox"/> 893 ApoB Mutation Analysis	
Obesity		
<input type="checkbox"/> 884	Early Onset Obesity Evaluation	LEPR, MC4R
	<input type="checkbox"/> 883 Early Onset Obesity (LEPR) DNA Sequencing Test	
	<input type="checkbox"/> 640 Early Onset Obesity (MC4R) DNA Sequencing Test	
<input type="checkbox"/> 887	Bardet-Biedl Syndrome Evaluation	BBS1, BBS2, BBS10
	<input type="checkbox"/> 871 BBS1 (BBS) DNA Sequencing Test	
	<input type="checkbox"/> 872 BBS2 (BBS) DNA Sequencing Test	
	<input type="checkbox"/> 886 BBS10 (BBS) DNA Sequencing Test	

Test Code	Test Name	Genes Included
Reproductive Disorders		
<input type="checkbox"/> 817	Male Precocious Puberty (LHCGR) DNA Sequencing Test	
<input type="checkbox"/> 679	Complete Kallmann/IHH Evaluation	CHD7, KAL1, PROK2, PROKR2, FGF8, FGFR1, GnRHR, GnRH1, KISS1R, TACR3
<input type="checkbox"/> 667	Normosmic Kallmann/IHH Evaluation	PROK2, PROKR2, FGFR1, GnRHR, GnRH1, TACR3, KISS1R
<input type="checkbox"/> 462	Anosmic Kallmann/IHH Evaluation	KAL1, PROK2, PROKR2, FGF8, FGFR1, GnRHR, KISS1R
<input type="checkbox"/> 173	KAL1 DNA Sequencing Test	
<input type="checkbox"/> 175	PROK2 DNA Sequencing Test	
<input type="checkbox"/> 180	PROKR2 DNA Sequencing Test	
<input type="checkbox"/> 195	FGF8 DNA Sequencing Test	
<input type="checkbox"/> 196	FGFR1 DNA Sequencing Test	
<input type="checkbox"/> 279	GnRHR DNA Sequencing Test	
<input type="checkbox"/> 343	GnRH1 DNA Sequencing Test	
<input type="checkbox"/> 358	TACR3 DNA Sequencing Test	
<input type="checkbox"/> 364	KISS1R DNA Sequencing Test	
<input type="checkbox"/> 461	CHD7 DNA Sequencing Test	

Test Code	Test Name	Genes Included
Short Stature		
<input type="checkbox"/> 865	Combined Pituitary Hormone Deficiency Evaluation	PROP1, POU1F1
<input type="checkbox"/> 863	PROP1 (CPHD) DNA Sequencing Test	
<input type="checkbox"/> 864	POU1F1 (CPHD) DNA Sequencing Test	
<input type="checkbox"/> 848	Growth Hormone Deficiency Evaluation	GH1 and GHRHR Seq.; SHOX Seq. and Del.
<input type="checkbox"/> 866	GH1 (GHD) DNA Sequencing Test	
<input type="checkbox"/> 868	GHRHR (GHD) DNA Sequencing Test	
<input type="checkbox"/> 847	SHOX (GHD) DNA Sequencing and Deletion Test	
<input type="checkbox"/> 867	GHR DNA Sequencing Test	
Noonan Syndrome		
<input type="checkbox"/> 846	Noonan Syndrome (PTPN11) DNA Sequencing Test	
<input type="checkbox"/> 658	KRAS/RAF1/SOS1 DNA Sequencing Evaluation	SOS1, RAF1, KRAS
<input type="checkbox"/> 662	SOS1 DNA Sequencing Test	
<input type="checkbox"/> 663	RAF1 DNA Sequencing Test	
<input type="checkbox"/> 664	KRAS DNA Sequencing Test	

Specimen Requirements: 8 mL (6 mL minimum) whole blood collected in an EDTA (lavender-top) tube.

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Athena Diagnostics Client Service Representatives are available from 8:30am to 9:00pm Eastern Time (U.S.). Customers in the U.S. and Canada please call toll-free

800-394-4493

(Non-U.S. customers please call 508-756-2886 or fax 774-843-3721.)



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