

# Athena Diagnostics Nephrology 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

## 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 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](http://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.**

**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](http://AthenaDiagnostics.com) for complete specifications and shipping information. Reflex testing will be performed at an additional charge.

**Note:** Test requisitions become outdated. For the most accurate and up-to-date test offering, please visit [AthenaDiagnostics.com](http://AthenaDiagnostics.com).

STOP  
Signature  
Required  
Here

# Nephrology Patient Insurance Test Requisition (January 2017)

**Important: Please be sure to write in test code and test name in the Tests Ordered section on front.**

Test Code		Pref. Spec.	Pref. Vol.	Tube Type	Test Code		Pref. Spec.	Pref. Vol.	Tube Type
<b>Alport Syndrome</b>					<b>Nephrotic Syndrome</b>				
<input type="checkbox"/> 759	<b>Complete Alport Syndrome Evaluation</b> (COL4A3,4,5 DNA Sequencing; COL4A5 Deletion Test)	B	8 mL	L	<input type="checkbox"/> 722	<b>Early Onset Nephrotic Syndrome Evaluation</b> (PLCE1, LAMB2, WTI, NPHS1, NPHS2)	B	8 mL	L
<input type="checkbox"/> 755	COL4A5 Sequencing and Deletion Analysis	B	8 mL	L	<input type="checkbox"/> 717	<b>Focal and Segmental Glomerulosclerosis (FSGS) Evaluation</b> (INF2, ACTN4, TRPC6, NPHS2)	B	8 mL	L
<input type="checkbox"/> 756	COL4A5 Deletion Analysis	B	8 mL	L	<input type="checkbox"/> 711	ACTN4 DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 757	COL4A3 DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 712	TRPC6 DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 758	COL4A4 DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 716	INF2 DNA Sequencing Test	B	8 mL	L
<b>Amyloidosis</b>					<input type="checkbox"/> 718	PLCE1 DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 235	TTR DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 713	WTI DNA Sequencing Test	B	8 mL	L
<b>Bardet-Biedl Syndrome</b>					<input type="checkbox"/> 714	LAMB2 DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 887	<b>Bardet-Biedl Syndrome Evaluation</b> (BBS1, BBS2, BBS10)	B	8 mL	L	<input type="checkbox"/> 710	NPHS2 DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 871	BBS1 (BBS) DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 730	NPHS1 DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 872	BBS2 (BBS) DNA Sequencing Test	B	8 mL	L	<b>Polycystic Kidney Disease</b>				
<input type="checkbox"/> 886	BBS10 (BBS) DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 728	PKDx <sup>®</sup> Familial Mutation Evaluation (PKD1 and PKD2 Single Exon Sequencing)	B	8 mL	L
<b>Fanconi Syndrome</b>						Proband Accession # _____ Relationship _____			
<input type="checkbox"/> 517	MELAS mtDNA Evaluation (MELAS 3243, 3271, 3252, 3256, 3291, 13513)	B	8 mL	L	<input type="checkbox"/> 8100	Complete PKDx Evaluation	B	8 mL	L
<b>Family Testing</b>					<input type="checkbox"/> 8105	PKD1 Deletion Test	B	8 mL	L
<input type="checkbox"/> 185	<b>Familial DNA Sequence Evaluation</b> This test detects previously identified sequence variants in at-risk family members. Proband Accession # _____ Relationship _____	B	8 mL	L	<input type="checkbox"/> 8101	PKD1 DNA Sequencing and Deletion Evaluation	B	8 mL	L
<b>Hereditary Renal Tubular Disorders</b>					<input type="checkbox"/> 8103	PKD1 DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 767	<b>Hereditary Renal Tubular Disorders Evaluation</b> (SLC12A1, KCNJ1, CLCNKB, BSND, SLC12A3)	B	8 mL	L	<input type="checkbox"/> 8106	PKD2 Deletion Test	B	8 mL	L
<input type="checkbox"/> 762	SLC12A1 DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 8102	PKD2 DNA Sequencing and Deletion Evaluation	B	8 mL	L
<input type="checkbox"/> 763	KCNJ1 DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 8104	PKD2 DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 764	CLCNKB DNA Sequencing Test	B	8 mL	L	<b>Other Cystic Diseases</b>				
<input type="checkbox"/> 765	BSND DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 556	<b>Complete Tuberosus Sclerosis Evaluation</b> (TSC1 Sequencing, TSC1 Deletion, TSC2 Sequencing, TSC2 Deletion)	B	8 mL	L
<input type="checkbox"/> 766	SLC12A3 DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 521	TSC1 DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 825	CASR DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 508	TSC1 Deletion Test	B	8 mL	L
<b>Monogenic Hypertension</b>					<input type="checkbox"/> 522	TSC2 DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 749	<b>Monogenic Hypertension Evaluation</b> (SCNN1B, SCNN1G, CYP11B1, HSD11B2)	B	8 mL	L	<input type="checkbox"/> 523	TSC Familial Mutation Evaluation Proband Accession # _____ Relationship _____	B	8 mL	L
<input type="checkbox"/> 747	Liddle's Syndrome Evaluation (SCNN1B, SCNN1G)	B	8 mL	L	<input type="checkbox"/> 524	TSC2 DNA Deletion Test	B	8 mL	L
<input type="checkbox"/> 748	Pseudohypoaldosteronism Type 1 Evaluation (SCNN1A, SCNN1B, SCNN1G)	B	8 mL	L	<input type="checkbox"/> 770	Hereditary Interstitial Kidney Disease (UMOD) DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 772	SCNN1A DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 836	TCF2 DNA Sequencing Test (Renal Cysts and Diabetes Syndrome (RCAD))	B	8 mL	L
<input type="checkbox"/> 745	SCNN1B DNA Sequencing Test	B	8 mL	L	<b>Renal Cancer</b>				
<input type="checkbox"/> 746	SCNN1G DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 889	<b>Pheochromocytoma Evaluation</b> (RET, VHL, SDHB)	B	8 mL	L
<input type="checkbox"/> 774	CYP11B1 DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 813	MEN2 (RET) DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 775	HSD11B2 DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 818	MEN1 (MEN1) DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 779	CYP11B1/CYP11B2 Chimeric Gene Fusion Test	B	8 mL	L	<input type="checkbox"/> 888	SDHB DNA Sequencing Test	B	8 mL	L
<b>Nephrogenic Diabetes Insipidus</b>					<input type="checkbox"/> 858	von Hippel-Lindau Syndrome (VHL) DNA Sequencing Test	B	8 mL	L
<input type="checkbox"/> 854	<b>Nephrogenic Diabetes Insipidus Evaluation</b> (AVPR2, AQP2)	B	8 mL	L	<b>Renal Cysts and Diabetes</b>				
<input type="checkbox"/> 851	AVPR2 DNA Sequencing Test	B	8 mL	L	<input type="checkbox"/> 776	HNFI8 DNA Sequencing and Deletion Evaluation (RCAD)	B	8 mL	L
<input type="checkbox"/> 852	AQP2 DNA Sequencing Test	B	8 mL	L	<b>Rickets</b>				
<b>Nephronophthisis</b>					<input type="checkbox"/> 857	<b>Hypophosphatemic Rickets Evaluation</b> (PHEX, FGF23)	B	8 mL	L
<input type="checkbox"/> 750	NPHPI Deletion Test (Familial Juvenile Nephronophthisis)	B	8 mL	L	<input type="checkbox"/> 855	PHEX (Hypophosphatemic Rickets) DNA Sequencing Test	B	8 mL	L
					<input type="checkbox"/> 856	FGF23 (Hypophosphatemic Rickets) DNA Sequencing Test	B	8 mL	L

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

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**Athena Diagnostics, Inc., 200 Forest Street, 2nd Floor, Marlborough, MA 01752 • AthenaDiagnostics.com • 800-394-4493**

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