MEDEX LABORATORIES

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ORDER FORM NEURO-DEGENERATIVE DISEASES

PATIENT INFORMATION

First Name:.....

Last Name:.....

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:.....

NPI#:.....

SPECIMEN INFORMATION

☐ DNA ____ µg (min. 5 µg DNA, concentr. ≥ 50 ng/µl) DNA-No.:.....

☐ Other specimen:.....

External ID: .....

Date of sample collection: .....

Samples can be sent by mail in a cardboard box or air cushion envelope. Samples should not be exposed to direct sunlight. Dried blood spot cards can be ordered for free (info@cegat.com).

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 #:.....

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Jewish(Ashkenazi) ☐ Portuguese ☐ Other.....

FAMILY MEDICAL HISTORY

Are there other family members who currently have or have had the same or a similar disease as the patient? ☐ Yes ☐ No

If yes, please list the affected family members:

Name (Optional)	Relationship to the patient (e.g. mother)	Age of onset	Diagnosis / Symptoms

☐ **Comprehensive Neurogenerative Diseases Panel :** PLCG2, TBP, TP53INP1, APOE, ANG, SOD1, TOR1A, PRNP, PSEN1, GCH1, PINK1, ARDBP, APTX, APP, PSEN2, PARK2, POLG, OPTN, FUS, SPAST, FIG4, SETX, MAPT, GRN, NOTCH3, LRRK2, ATM, CLU, PICALM, CR1, BIN1, CD33, MS4A4A, MS4A6E, CD2AP, EPHA1, ABCA7, CASS4, CELF1, FERMT2, INPP5D, MEF2C, NME8, PTK2B, SLC24A4, RIN3, SORL1, ZCWPW1, TREM2, ADAM10, PVRL2, ABI3, CSF1R, TRIP4, VPS35, SNCA, PRKRA, GBA, RAB39B, TMEM230, RAB7L1, VPS13C, PARK7, ATP13A2, PLA2G6, FBXO7, SYNJ1, DNAJC6, SCARB2, CHCHD2,, PANK2, TAF1, GAK, ADORA1, EIF4G1, ATP6AP2, GIGYF2, HTRA2, VCP, PFN1, SQSTM1, UBQLN2, CHMP2B, NEFH, TBK1, NEK1, CHCHD10, TUBA4A, UNC13A, SARM1, C21orf2, EPHA4, LMNB1, DCTN1, HNRNPA1, HNRNPA2B1, VAPB, ALS2, TMEM106B, RAB38, CTSC, BTNL2, TOMM40, CLCN6, MARK2, MARK4, EP300, AKT1, SGTA, ELAVL1, THAP1, PRRT2, ANO3, TH, ATP1A3, DNMT1, ITM2B, TYROBP

ICD-10 DX CODE (s):

Diseases of the nervous system (G00–G99)
Other degenerative diseases of the nervous system (G30-G32)
G30 - Alzheimer's disease
G30.0 - Alzheimer's disease with early onset
G30.1 - Alzheimer's disease with late onset
G30.8 - Other Alzheimer's disease
G30.9 - Alzheimer's disease, unspecified
Oth degenerative diseases of nervous system, NEC (G31)
G31 - Oth degenerative diseases of nervous system, NEC
G31.8 - Other specified degenerative diseases of nervous system
GG31.0 - Frontotemporal dementia
G31.01 - Pick's disease
G31.09 - Other frontotemporal dementia
G31.1 - Senile degeneration of brain, not elsewhere classified
G31.2 - Degeneration of nervous system due to alcohol
31.81 - Alpers disease
G31.82 - Leigh's disease
G31.83 - Dementia with Lewy bodies
G31.84 - Mild cognitive impairment, so stated
G31.85 - Corticobasal degeneration
G31.89 - Other specified degenerative diseases of nervous system
G31.9 - Degenerative disease of nervous system, unspecified
Oth degeneratv disord of nervous sys in dis classd elswhr (G32)
G32 - Oth degeneratv disord of nervous sys in dis classd elswhr
G32.0 - Subac comb degeneration of spinal cord in dis classd elswhr
G32.8 - Oth degeneratv disord of nervous sys in dis classd elswhr
G32.81 - Cerebellar ataxia in diseases classified elsewhere
G32.89 - Oth degeneratv disord of nervous sys in dis classd elswhr

PATIENT SIGNATURE

I hereby assign all rights and benefits under my health plan and all rights and obligations that I and my dependents have under my health plan to **Medex Laboratories Inc**. its assigned affiliates and authorized representatives for laboratory services furnished to me by **Medex Laboratories Inc.** I irrevocably designate, authorize and appoint **Medex Laboratories Inc.** or its assigned affiliates and their authorized representatives as my true and lawful attorney-in-fact for the purpose of submitting my claims, obtain a copy of my health plan document, Summary Plan Description, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with 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 **Medex Laboratories Inc.** immediately upon receipt. I hereby authorize **Medex Laboratories Inc.** its assigned affiliates and authorized representatives to contact me or my health Plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that I have provided to **Medex Laboratories Inc.,** in compliance with federal and state laws. **Medex Laboratories Inc.**, its assigned affiliates and their authorized representatives may release to my health plan administrator, my employer, and my authorized representative my personal health information for the purpose of procuring payment of **Medex Laboratories Inc.** and for all the laboratory services. I understand the acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance.

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

ORDERING PHYSICIAN SIGNATURE

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

I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder and that the results will be used in medical management and care decisions for the patient. Furthermore, all information on this Requisition Form is true to the best of my knowledge. I agree to provide the Care Plan notes and Letter of Intent for this order if the insurance requests the lab to gather the medical necessity for any reason

Ordering Physician Signature Date: