MEDEX LABORATORIES

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

PHARMACOGENOMICS TEST REQUISITION

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

Date pf Collection (MM/DD/YY):.....
Time of Collection:.....Specimen Type: ☐ Buccal Swab
ICD10 DX Code(s):.....
(Please Refer Below Diagnosis Section)

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 #:.....
Insurance Name:.....
Member Policy #:.....

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

ORDER TEST

(Please list special instructions for the individual patient below)

☐ **Pharmacogenomics Comp Panel** — **CYP1A2, DPYD, ACE, F2, IFNL4, CYP2B6, AGTR1, HTR2C, TPMT, HTR2A, LDLR, UGT1A, GRIK4, F5, CYP2C19, RYR1, SLCO1B1, CYP2C8, CYP2C9, CYP2D6, CACNA1C, MTHFR, UGT1A1, CYP3A4, APOE, UGT1A4, CYP4F2, C11orf65, DPYD, CYP2D6, OPRM1, APOB, COMT, CYP3A5, CYP2A13, CYP3A43, NUDT15, CACNA1S, ZSCAN25, HCP5, CYP2R1, UGT1A10, RARG, SLC28A3, CYP2F1, CFTR, CYP3A7, CYP2A43**

COLUMN 1* (SELECT ALL THAT MAY APPLY):

F31.30	Bipolar disorder, current episode depressed mild Or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depresses, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without pyshotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.63	Bipolar disorder, current episode mixed, severe, without pyschotic features
F32.89	Other Specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent moderate
F33.2	Major depressive disorder, recurrent severe without pyschotic
F33.3	Major depressive disorder, recurrent severe with Pyschotic
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.9	Major depressive disorder, recurrent, unspecified

COLUMN 2* (SELECT ALL THAT MAY APPLY):

I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
I25.111	Atherosclerotic heart disease of native coronary artery w/angina pectoris w/documnted spasm
I25.5	Ischemic cardiomyopathy
I25.6	Silent myocardial ischemia
I25.720	Atherosclerotic heart disease of native coronary artery bypas grafts with unstable angina pectoris
I25.728	Atherosclerotic heart disease of native coronary artery bypas graft(s) with other forms angina pectoris
I25.760	Atherosclerotic heart disease of native coronary artery transplanted heart with unstable angina
I25.790	Atherosclerotic heart disease of native coronary artery bypass graft(s) with unstable angina pectoris
I25.798	Atherosclerotic heart disease of native coronary artery bypass graft(s) with other forms of angina pectoris
I25.810	Atherosclerotic heart disease of native coronary artery bypass graft(s) without angina pectoris
I25.812	Atherosclerotic of bypass graft of coronary artery of transplanted heart w/o angina pectoris
I25.89	Other forms of chronic ischemic heart disease
I25.9	Chronic ischemic heart disease, unpecified
I66.8	Occusion and stenosid of pther cerebral arteries
Z79.02	Long term (current) use of antithrombotics/antiplatelets

PRESCRIBED MEDICATIONS

Please list all current medications or attach additional sheets as necessary

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: