

Cytogenetics Request Form

106 Gregor Mendel Circle • Greenwood, SC 29646

Toll Free: (800) 473-9411 • Fax: (864) 941-8141

Website: www.ggc.org **Highlighted boxes are required**

LAB USE ONLY

Patient Information (Please Print):

Last Name		First	MI	Address		
Race/Ethnicity			Sex <input type="checkbox"/> M <input type="checkbox"/> F	DOB MM/DD/YYYY	City, State, Zip	
Specimen Collection Date MM/DD/YYYY		Type of specimen*		Numeric Identifier (Medical record # or SSN)		Home telephone
*DNA samples only: Please identify where DNA extraction was performed. <input type="checkbox"/> CAP/CLIA Accredited Lab: _____ <input type="checkbox"/> Research Lab: _____ <input type="checkbox"/> Unknown						

Referring Physician:

Name			Address			
Institution			City, State, Zip			
NPI#			Telephone		Fax	
Email Address:			Preferred Method to Receive Results: <input type="checkbox"/> Secure Email <input type="checkbox"/> Fax <input type="checkbox"/> Regular Mail			

Additional report to: Genetic Counselor Institution Care Coordinator Other:

Name			Address			
Telephone	Fax	Email:		City, State, Zip		

Additional report to: Genetic Counselor Institution Care Coordinator Other:

Name			Address			
Telephone	Fax	Email:		City, State, Zip		

Billing: Select how the test(s) will be billed & complete the billing information on the next page. **The BILLING FORM on page 2 is required.**

Institutional Billing: Complete section 1 on the separate [BILLING FORM](#) (page 2)

Insurance: Complete section 2 on the [BILLING FORM](#) (page 2). No out-of-state (non-SC) insurance or Medicaid will be accepted.

Self-pay: Complete section 3 on the separate [BILLING FORM](#) (page 2).

Indication for Study & Clinical Information: Please attach pedigree

ICD10 Code(s): _____

Symptomatic, specific findings: _____

Family History _____

Is the patient currently pregnant? No Yes If so, provide LMP: _____ or EDD: _____ Gestational Age: _____

Ultrasound findings _____

CHROMOSOME STUDIES •*

- High Resolution Chromosomes
- High Resolution Chromosomes, Rule Out Mosaic
- Routine Blood Chromosomes
- Routine Blood Chromosomes, Rule Out Mosaic
- Routine Blood Chromosomes, Short Study
- Solid Tissue Chromosomes
- Solid Tissue Chromosomes, Rule Out Mosaic

AMNIOTIC FLUID STUDIES *

- Chromosomes, Routine
- AFP AChE (Sendouts)
- Chromosomes, Short Study
- AFP AChE (Sendouts)
- Trisomy Screen – FISH (13,18,21,X,Y)

CHORIONIC VILLUS SAMPLING (CVS) *

- Chromosomes
- Trisomy Screen – FISH (13,18,21,X,Y)
- Maternal Cell Contamination ► **Required**

MICROARRAY ►*

- CytoScan HD Microarray
- CytoScan Xon Array Specify Gene(s) _____
- Array Confirmation – Parental Studies
Please Specify Proband: _____
- Prenatal Microarray
Parent Samples Included:
 Mom's Sample
 Dad's Sample (separate requisition required)
- Pregnancy Loss (POC) Microarray
 Maternal Cell Contamination ► **Recommended**
- Targeted Infertility Microarray
- FISH FOR CONGENITAL ABERRATIONS (Buccal) ^**
- Disorders of Sexual Development, Routine (includes SRY/Xcen & X/Y dual assay probes)
- Disorders of Sexual Development, Rule Out Mosaic (includes SRY/Xcen & X/Y dual assay probes)
- Trisomy Screen (13), Rule Out Mosaic
- Trisomy Screen (18), Rule Out Mosaic
- Trisomy Screen (21), Rule Out Mosaic

FISH FOR CONGENITAL ABERRATIONS (Blood) •*

- Angelman Syndrome (15q11q13)
- Autism (dup 15q12)
- Chromosome Enumeration Probes (all chromosomes available) Specify: _____
- Chromosome Paints (all chromosomes available) Specify: _____
- Cri du Chat Syndrome (5p-)
- DiGeorge/VCF Syndrome (22q11)
- Disorders of Sexual Development (includes SRY/Xcen & X/Y dual assay probes)
- Kallmann Syndrome (Xp22.3)
- Miller-Dieker Syndrome (17p13)
- Prader-Willi Syndrome (15q11q13)
- Smith-Magenis Syndrome (17p11.2)
- Steroid Sulfatase (Xp22.3)
- Trisomy Screen (13,18,21,X,Y)
- Williams Syndrome/Elastin and LIMK1 (7q11.23)
- Wolf-Hirschhorn Syndrome (4p-)
- OTHER**
- DNA Banking
- Cell Culture Only
- Other: _____

► Requires purple-top/EDTA tube • Requires green-top/sodium heparin tube *Room temperature/24 hour delivery ^Buccal (GGC Kit Required)

LAB USE ONLY Accessioned By: _____ Event Codes: _____ FedEx Eagle UPS DHL WC Other: _____								
EDTA	Na Hep	Plasma / Serum	Urine	Flasks / Tissue	DBS / DNA	Saliva / Swab Buccal	PAX	ACD
RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F	RT / R / F



Diagnostic Laboratory Billing Form
This page is required to process any test requests.

LAB USE ONLY

- **Out of State (non-SC) commercial insurance can only be filed for NGS Panels.**
- **No out of state Medicaid will be accepted for any tests.**
- **The following items are needed in order to bill the patient's insurance directly. We will not be able to file the claim if we are missing information.**
 - This form must be completed with ALL requested information.
 - A legible copy of both sides of the insurance card
 - Authorization number, authorization letter, or letter of agreement from insurance company

Patient Information:

Last Name	First	MI	Address	
Numeric Identifier (Medical record # or SSN)		DOB MM/DD/YYYY	City, State, Zip	Telephone
ICD10 Code(s)				

Section 1: Institutional Billing

Complete section below with institution information. *New clients must complete an [INSTITUTIONAL ACCOUNT REQUEST FORM](#) when submitting the order.* Please contact the GGC Billing Office at 864-941-8117 or billing@ggc.org with any questions about your account.

Institution/Organization	Contact Name:	Email:
Billing Address	City, State, Zip	
Account Number:	Telephone	Fax

Section 2: Insurance Information **INSURANCE OR MEDICAID FOR OUT-OF-STATE (NON-SC) PATIENTS IS NOT ACCEPTED**

MUST INCLUDE LEGIBLE COPY OF INSURANCE CARD (FRONT & BACK)
All information required to file insurance claims.

Primary		
Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone
Secondary		
Insured/Policy Holder Name:	Policy Holder DOB:	Policy Holder Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other:	Policy #	
Insurance Company Name:	Insurance ID #:	
Group #:	Insurance Address	
Authorization Number (attach copy of authorization letter) *Required	Insurance City, State, Zip	Phone

I authorize Greenwood Genetic Center (GGC) Diagnostic Laboratories to furnish any medical information requested of me, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to GGC Diagnostic Laboratories. I understand I am responsible for any co-pay, deductibles, non-authorized, or non-covered services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if the GGC Diagnostic Laboratories is not a participant with my health plan, or my health plan does not fully reimburse my medical services due to lack of authorization for medical necessity.

Printed Name: _____ Signature: _____ Date (MM/DD/YY): _____

Section 3: Self-pay

We accept check/Visa/MasterCard/American Express/Discover. All information required to process credit card payments.
Payments will be processed prior to initiation of testing.

Payment Method: <input type="checkbox"/> Check <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AmEx <input type="checkbox"/> Discover	Credit Card Number:		
Amount: (with discount applied if applicable)	Exp. Date	CVV	
Cardholder Name(print as it appears on the card):	Cardholder Signature:	Date	
Billing address	City, State, Zip	Telephone	