# 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 ☐ M ☐ F | DOB MM/DD/YYYY | City, State, Zip |
| Specimen Collection Date MM/DD/YYY | Type of specimen* | Numeric Identifier (Medical record # or SSN) | Home telephone |

*DNA samples only: Please identify where DNA extraction was performed.
☐ **CAP/CLIA Accredited Lab:** _____ ☐ **Research Lab:** _____ ☐ **Unknown**

**Referring Physician:**

| Name | Address | |
|---|---|---|
| Institution | City, State, Zip | |
| NPI# | Telephone | Fax |
| Email Address: | Preferred Method to Receive Results: ☐ Secure Email ☐ Fax ☐ 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 EDC: _____ 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
☐ 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**

**OTHER**
☐ DNA Banking
☐ Cell Culture only
☐ Other: _____

**MICROARRAY ►***
☐ CytoScan DX Microarray
(FDA cleared/peripheral blood only)
One or more of the following must be present:
☐ Developmental delays
☐ Intellectual disability
☐ Congenital anomalies
Specify: _____
☐ Dysmorphic features
Specify: _____
☐ 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*
☐ Targeted Infertility Microarray

**FISH FOR CONGENITAL ABERRATIONS ●***
☐ 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 Panel
(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-)

► **Requires purple-top/EDTA tube** ● **Requires green-top/sodium heparin tube** * **Room temperature/24 hour delivery**

**LAB USE ONLY** Accessioned By: Event Codes: FedEx BeavEx 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 |

Greenwood Diagnostic Labs

# 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 ☐ Male ☐ Female |
|---|---|---|
| Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent ☐ 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 ☐ Male ☐ Female |
|---|---|---|
| Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent ☐ 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. All information required to process credit card payments.**

**Payments will be processed prior to initiation of testing.**

| Payment Method: ☐ Check ☐ Visa ☐ MasterCard | 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 |