Oncology Testing Request Form

Greenwood Diagnostic Labs
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

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:

☐ ICD10 Code(s): _____

☐ Symptomatic, specific findings: _____

HEMATOLOGY/ONCOLOGY
CYTOGENETIC STUDIES
CHROMOSOME ANALYSIS

☐ Bone marrow *
☐ Stimulated/Unstimulated blood●
Specify WBC count: _____
☐ Lymph Nodes

FISH PANELS ●*

☐ Acute Lymphocytic Leukemia (ALL)
☐ Acute Myelocytic Leukemia (AML)
☐ Acute Promyelocytic Leukemia (APL)
☐ Chronic Lymphocytic Leukemia (CLL)
☐ Chronic Myelocytic Leukemia (CML)
☐ Chronic Myelomonocytic Leukemia (CMML)
☐ Multiple Myeloma (MM)
☐ Myelodysplastic States (MS)
☐ Non-Hodgkins Lymphoma (NHL)
☐ Pediatric Acute Lymphoblastic Leukemia (P-ALL)
☐ Reflex Panel for IgH breakapart
Includes t(8;14), t(14;18), t(11;14)

HEMATOLOGY/ONCOLOGY
CYTOGENETIC STUDIES
INDIVIDUAL PROBES ●*

☐ 9q34
☐ ALK (2p23)
☐ AML1/ETO t(8;21)
☐ ATM (11q22.3)
☐ BCL2 (18q21)
☐ BCL6 (3q27)
☐ CCND1 xT (11q13)
☐ CDKN2A/p16 (9p21)
☐ CBFB (inv16)
☐ C-MYC (8q24)
☐ CSF1R (5q33-q34)
☐ D13S319 (13q14)
☐ D7S486 (7q31)
☐ D20S108/MYBL2 (20q12 / 20q11.2)
☐ ETV6/RUNX1
☐ IgH (14q32)
☐ IgH/BCL2 t(14;18)
☐ IgH/CCND1 t(11;14)
☐ IgH/MYC/CEP 8 t(8;14)
☐ MLL (11q23)
☐ TP53/ p53 (17p13.1)

HEMATOLOGY/ONCOLOGY
MOLECULAR STUDIES
ARRAYS►^ *

☐ Chronic Lymphocytic Leukemia (CLL) Array
Includes analysis for trisomy 21, RB1 deletions, TP53 deletions, & ATM deletions
☐ Acute Myelocytic Leukemia (AML) Array
Includes genomic gains, losses & LOH
☐ Acute Lymphocytic Leukemia (ALL) Array
Includes genomic gains, losses & LOH
☐ Chronic Myelocytic Leukemia (CML) Array
Includes genomic gains, losses, & LOH for cytogenetically normal CML
☐ OncoScan array comprehensive analysis
(any FFPE tumor tissue)

Mutation Analysis►^ *

☐ **AML**(includes *FLT*-3ITD, & *FLT*-3TKD mutations ; *NPM1* codon 12)
☐ Other _____

►Requires purple top tube ● Requires sodium heparin tube * Bone Marrow ^FFPE or Fresh/Frozen Tissue

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

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

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)	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)	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