



Biochemical Diagnostic 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

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:

- Institutional Billing:** Complete section 1 on the separate [BILLING FORM](#) (page 2)
- Insurance:** Complete section 2 on the [BILLING FORM](#) (page 2). Insurance or Medicaid for out-of-state (non-SC) patients is not accepted.
- Self-pay:** Complete section 3 on the separate [BILLING FORM](#) (page 2).

Indication for Study & Clinical Information:

<input type="checkbox"/> ICD 10 Code(s): _____ <input type="checkbox"/> Symptomatic, specific findings: _____ <input type="checkbox"/> Family History _____ <input type="checkbox"/> Medications or treatment : _____ Is the patient currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, provide LMP date: _____ or EDC: _____ Please attach pedigree	Is this patient currently on enzyme replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, name of therapy: _____ Has this patient had a stem cell transplant: <input type="checkbox"/> Yes <input type="checkbox"/> No If so, date of transplant: _____ Has this patient had a blood transfusion: <input type="checkbox"/> Yes <input type="checkbox"/> No If so, date of transfusion: _____ If so, type of transfusion: <input type="checkbox"/> PRBC <input type="checkbox"/> FFP <input type="checkbox"/> Platelets Previous Testing: _____ _____
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General sample and shipping requirements **Please note that accepted sample types are specific to the individual test(s) being requested.**

Dried Blood Spot (D) - Fill at least 3 circles completely with a single layer of blood for each circle. Dry spots 3-4 hours prior to sending. Additional instructions are available at: http://www.ggc.org/images/DSB_Sample_Collection_Requirements.pdf

Fibroblasts (F) – Fresh tissue should be placed in transport media (preferred) or sterile saline and shipped overnight. For cultured tissue, please send two T25 flasks overnight. If cultured tissue is being sent, a control flask is requested in addition to the patient sample.

Leukocytes (L) – Blood in sodium heparin (green top) tube, must arrive within 24 hours of draw. Ship overnight at room temperature.

Plasma (P) – Sodium heparin (green top) tube. Ship whole blood overnight at room temperature OR spin down, remove plasma, and send plasma frozen.

Serum (S) – Red top tube. Ship whole blood overnight at room temperature OR spin down, remove serum, and send serum frozen.

Urine – Send frozen.

Whole blood (WB) – Blood in sodium heparin (green top) tube, must arrive within 24 hours of draw. Ship overnight at room temperature.

For molecular testing of metabolic genes, please complete a Molecular Lab Request Form.
Prenatal molecular studies require prior approval. Please contact the lab for specimen requirements.

LAB USE ONLY		Accessioned By:		Event Codes:		FedEx		Eagle		UPS		DHL		WC		USPS		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	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	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	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

Last Name	First	MI	DOB	Numeric Identifier (Medical record # or SSN)
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ANALYTES

Panels

- Biochemical Genetics Profile** – requires plasma & urine
Includes: quantitative plasma amino acids, plasma acylcarnitine profile, plasma total & free carnitine, and qualitative urine organic acids
- Storage Disease Panel** – urine
Includes: MPS analysis (quantitative HS/DS/CS/KS & GAGs), Oligosaccharides analysis, and Sialic Acid, total and free

Individual Analytes

- Acylcarnitine profile – plasma
- Amino acids – plasma (quantitative)
- Amino acids – urine (quantitative)
- Amino acids – CSF
- C5-DC (glutaryl carnitine) – urine
- Carnitine, total and free – plasma
- Creatine – urine (Creatine transporter only)
- Creatine/GAA – urine (Creatine biosynthesis disorders)
- Creatine/GAA – plasma (Creatine biosynthesis disorders)
- Galactose-1-phosphate – (red blood cells, sodium heparin tube)
- Homocysteine– plasma
- MPS urine analysis (quantitative HS/DS/CS/KS & total GAGs)
- Oligosaccharides analysis – urine
- Organic acids – urine
- Orotic acid – urine
- Sialic Acid, total and free – urine
- Total Glycosaminoglycans (GAGs), quantitative – urine
- Tryptophan – plasma

MONITORING TESTS

Mucopolysaccharidoses

- MPS I/II (Total GAGs, DS, HS) - urine
- MPS III (Total GAGs, HS) – urine
- MPS IV (Total GAGs, KS, CS) – urine
- MPS VI (Total GAGs, DS) – urine
- MPS VII (Total GAGs, DS, CS) – urine

Gaucher Disease

- Chitotriosidase – plasma

Pompe Disease

- Glucose tetrasaccharide (Glc4) – urine

- DNA Banking – requires purple-top (EDTA) tube

- Other _____

ENZYMES

Panels

- Dried Blood Spot Lysosomal Panel – 12 enzymes (D)**
Alpha-mannosidosis, Aspartylglucosaminuria, Beta-mannosidosis, Fabry, Fucosidosis, Gaucher, GM1 gangliosidosis, Krabbe, Niemann-Pick A/B, Neuronal Ceroid Lipofuscinosis 2, Pompe, & Schindler
- Dried Blood Spot Mucopolysaccharidosis Panel – 7 enzymes (D)**
MPS I, II, III B, IV A & B, VI and VII
- Hydrops Panel – 4 enzymes (skin fibroblasts only)**
Gaucher, GM1 gangliosidosis, Sialidosis & Sly syndrome
- Lysosomal Panel – 13 enzymes (WB)**
Alpha-mannosidosis, Aspartylglucosaminuria, Beta-mannosidosis, Fabry, Fucosidosis, Gaucher, GM1 gangliosidosis, Hurler, Krabbe, Metachromatic Leukodystrophy, Niemann-Pick A/B, Schindler, & Tay-Sachs/Sandhoff
- Morquio Syndrome Panel – 2 enzymes (WB, L, F, D)**
MPS IV A & B
- Mucolipidosis II/III Dried Blood Spot Screen – 4 enzymes (D)**
Acid sphingomyelinase, Alpha-iduronidase, Alpha-mannosidase, & Beta-glucosidase
- Mucolipidosis II/III Plasma Screen – 3 enzymes (WB, P)**
Alpha-fucosidase, Beta-glucuronidase, Hexosaminidase
- Mucopolysaccharidosis (MPS) Panel – 10 enzymes (WB, F)**
MPS I, II, III A-D, IV A & B, VI and VII *requires 2 green tops
- Multiple Sulfatase Deficiency Panel – 3 enzymes (WB, D, F)**
Arylsulfatase B, Iduronate-2-sulfatase, & N-acetyl-galactosamine-6-sulfatase
- Neurological Panel – 9 enzymes (WB)**
Fabry, Gaucher, GM1 gangliosidosis, Krabbe, Metachromatic Leukodystrophy, Neuronal Ceroid Lipofuscinosis 1, Neuronal Ceroid Lipofuscinosis 2, Niemann-Pick A/B, & Tay-Sachs/Sandhoff
- Oligosaccharidoses Panel – 6 or 7 enzymes (WB, L, D, F)**
Alpha-mannosidosis, Aspartylglucosaminuria, Beta-mannosidosis, Fucosidosis, GM1 gangliosidosis, & Schindler (Sialidase only if fibroblasts are submitted)
- Sanfilippo Syndrome Panel – 4 enzymes (WB, F)**
MPS III A-D

INDIVIDUAL ENZYMES

(Whole blood accepted for all individual enzymes except sialidosis)

- | | |
|--|---------|
| <input type="checkbox"/> Alpha-mannosidosis (α-mannosidase) | L,F,D |
| <input type="checkbox"/> Aspartylglucosaminuria (aspartylglucosaminidase) | P,L,D |
| <input type="checkbox"/> Beta-mannosidosis (β-mannosidase) | L,F,D |
| <input type="checkbox"/> Biotinidase deficiency (biotinidase) | P,S |
| <input type="checkbox"/> Fabry disease (α-galactosidase) | P,L,F,D |
| <input type="checkbox"/> Fucosidosis (α-fucosidase) | L,F,D |
| <input type="checkbox"/> Gaucher disease (β-glucosidase) | L,F,D |
| <input type="checkbox"/> GM1 gangliosidosis (β-galactosidase) | L,F,D |
| <input type="checkbox"/> Hunter syndrome, MPS II (Iduronate-2-sulfatase) | P,L,F,D |
| <input type="checkbox"/> Hurler syndrome, MPS I (α-iduronidase) | P,L,F,D |
| <input type="checkbox"/> Krabbe disease (galactocerebrosidase) | D |
| <input type="checkbox"/> Maroteaux-Lamy syndrome, MPS VI (arylsulfatase B) | L,F,D |
| <input type="checkbox"/> Metachromatic leukodystrophy (arylsulfatase A) | L,F |
| <input type="checkbox"/> Morquio, type A (N-acetyl-galactosamine-6-sulfatase) | L,F,D |
| <input type="checkbox"/> Morquio, type B (β-galactosidase) | L,F,D |
| <input type="checkbox"/> Neuronal Ceroid Lipofuscinosis 1 (palmitoyl-protein thioesterase 1) | L |
| <input type="checkbox"/> Neuronal Ceroid Lipofuscinosis 2 (tripeptidyl peptidase 1) | D |
| <input type="checkbox"/> Niemann-Pick A/B (acid sphingomyelinase) | D |
| <input type="checkbox"/> Pompe disease (α-1,4-glucosidase) | L,F,D |
| <input type="checkbox"/> Sanfilippo A (heparan-N- sulfatase) | L,F |
| <input type="checkbox"/> Sanfilippo B (N-acetyl-α-glucosaminidase) | P,F,D |
| <input type="checkbox"/> Sanfilippo C (acetyl CoA:glucosamine N-acetyltransferase) | L,F |
| <input type="checkbox"/> Sanfilippo D (N-acetyl glucosamine-6-sulfatase) | L,F |
| <input type="checkbox"/> Schindler/Kanzaki Disease (N-acetyl-alpha galactosaminidase) | P,F,D |
| <input type="checkbox"/> Sialidosis (α-neuraminidase, sialidase) | F |
| <input type="checkbox"/> Sly syndrome, MPS VII (β-glucuronidase) | L,F,D |
| <input type="checkbox"/> Tay-Sachs/Sandhoff disease (β-hexosaminidase) *no carrier testing | L,P |