

Oncology Testing 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: 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: _____

**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 (MDS)
- 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 •***

- ABL (9q34) ^
- ALK (2p23)
- AML1/ETO t(8;21)
- ATM (11q22.3) ^
- BCL2 (18q21) ^
- BCL6 (3q27) ^
- CCND1 xT (11q13) ^
- CDKN2A/p16 (9p21) ^
- CFBF (inv16)
- C-MYC (8q24) ^
- CSF1R (5q33-q34) ^
- D13S319 (13q14) ^
- D7S486 (7q31)
- D20S108/MYBL2 (20q12 / 20q11.2)
- ETV6/RUNX1 t(12;21) ^
- 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

MUTATION ANALYSIS ▶ *

- AML(includes FLT-3ITD, & FLT-3TKD mutations)
- Other _____

▶ Requires purple top tube • Requires sodium heparin tube * Bone Marrow ^Lymph Nodes also accepted

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



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 <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	