CHROMOSOME STUDY REQUISITION

Center for Human Genetics, Inc.
Riverside Techology Center
840 Memorial Drive, Suite 101
Cambridge, MA 02139
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Phone: 617-492-7083 Fax: 617-492-7092
Website: http://www.chginc.org

FOR **CHG** LAB USE ONLY:
Date received: _____
Time: _____
Lab #: _____

Patient Name: _____
Last First MI

Date of Birth: _____

Address: _____

☐ **Male** ☐ **Female** ☐ **Unknown**

_____
City State Zip Code

SSN: _____

Phone: _____

Referring Provider: **NPI:**(10 digits required) _____

Name: _____

Address: _____

_____
City State Zip Code

Phone: _____ Fax: _____

Referring Laboratory (if different):

Name: _____

Address: _____

_____
City State Zip Code

Phone: _____ Fax: _____

Sample type:

□ Blood (Routine) □ Blood (Hem/Onc) □ Fetal tissue, type (specify): _____

□ Bone marrow □ Tumor □ Other (specify): _____

Collection Date: _____ **Time (AM/PM):** _____

ICD-10 Diagnosis (REQUIRED): _____

Clinical Diagnosis/Indication (specify):

_____

_____

_____

Chromosome Study Requested:

□ Routine
□ High resolution
□ Newborn [stat]
□ Other (specify): _____

FISH (fluorescent in situ hybridization) Studies:

□ Angelman (DNA test recommended, please see DNA Test Requisition Form)
□ Prader-Willi (DNA test recommended, please see DNA Test Requisition Form)
□ DiGeorge VCFS
□ Subtelomeric
□ Williams
□ Other (specify): _____

FOR **CHG** LAB USE ONLY:
Report date: _____ Contact: _____
Result: _____ Reported by: _____

*****BILLING INFORMATION AND COPY OF INSURANCE CARD FRONT AND BACK MUST ACCOMPANY SAMPLE AND REQUISITION FORM*****

SVC PROVIDER: CENTER FOR HUMAN GENETICS INC CLIA #22D0650242 NPI #1821153156

PATIENT INFORMATION:

LAST NAME: **FIRST NAME:** **MIDDLE:**	**GENDER: (CIRCLE)** **M F**	**DATE OF BIRTH** **/ /** **MM/DD/YYYY**
STREET ADDRESS:		**APARTMENT# / FLOOR**
CITY :	**STATE**	**ZIP**
PHONE: HOME( )	**CELL( )**	

PAYMENT INFO: (SELECT ONE) (CIRCLE): LAB/HOSP/FAC/INST INSURANCE PATIENT CREDIT CARD

BILLING INFORMATION (MUST BE COMPLETED)

LABORATORY/ HOSPITAL/ FACILITY/ INSTITUTIONAL BILLING ADDRESS:

FACILITY NAME: **AFFIX LABEL HERE:**
ADDRESS:
CITY, STATE, ZIP
ATTENTION:
PHONE: ( )
FAX: ( )
PURCHASE ORDER#
PATIENT MEDICAL RECORD#

INSURANCE INFORMATION:

INSURANCE COMPANY NAME:
INSURANCE IDENTIFICATION #
INSURANCE GROUP #

SUBSCRIBER NAME: **LAST:** **FIRST:**	**SUBSCRIBER DATE OF BIRTH:** **/ /** **MM / DD / YYYY**
RELATIONSHIP TO PATIENT:	**(CIRCLE):** **SELF PARENT SPOUSE**
INSURANCE ADDRESS: **STREET:**	**INSURANCE TELEPHONE AND EXTENTION:** **( )** **FAX# ( )** **CONTACT NAME/DEPT:**
CITY, STATE, ZIP:	**AUTHORIZATION#** **VALID FROM: / / TO / /**

***SECONDARY INS NAME:** **SUB NAME:** **RELATIONSHIP:**
POLICY # **SUB DOB: / /** **GENDER: M F**

PATIENT ACKNOWLEDGEMENT:
I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO ANY INSURANCE CARRIER ANY INFORMATION NEEDED FOR THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST THAT THE PAYMENT OF MEDICAL INSURANCE BE PAID TO CHG, INC. I ALSO UNDERSTAND THAT I WILL BE HELD RESPONSIBLE FOR ANY PORTION OF THE CLAIM THAT THE INSURANCE COMPANY DOES NOT PAY.

REQUIRED SIGNATURE: **DATE: / /**

MEDICARE ID#: **BENEFICIARY NAME:**

BENEFICIARY AGREEMENT:
I HAVE BEEN NOTIFIED BY THE CENTER FOR HUMAN GENETICS THAT, IN MY CASE, MEDICARE IS LIKELY TO DENY PAYMENT FOR THE SERVICES IDENTIFIED BELOW, FOR THE REASON STATED. IF MEDICARE DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT.

REQUIRED BENEFICIARY SIGNATURE: **DATE: / /**

MEDICARE WILL ONLY PAY FOR SERVICES THAT IT DETERMINES TO BE "REASONABLE AND NECESSARY" UNDER SECTION 1862(a) (1) OF THE MEDICARE LAW.
IF MEDICARE DETERMINES THAT A PARTICULAR SERVICE, ALTHOUGH IT WOULD OTHERWISE BE COVERED, IS NOT "REASONABLE AND NECESSARY" UNDER MEDICARE PAYMENT STANDARDS, MEDICARE WILL DENY PAYMENT FOR THAT SERVICE. THE CENTER FOR HUMAN GENETICS BELIEVES THAT MEDICARE IS LIKELY TO DENY PAYMENT FOR MOLECULAR DNA TESTING. **PROVIDER #228243**

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: