CANCER CYTOGENETIC STUDY REQUISITION

Center for Human Genetics, Inc.
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Website: http://www.chginc.org

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

Patient Name: _____
Last First MI

Address: _____
_____
_____
City State Zip Code

Phone: _____

Date of Birth: _____

□ **Male** □ **Female**

SSN: _____

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 ☐ Neoplastic Blood ☐ Bone marrow ☐ Tumor ☐ Other (specify): _____

ICD-10 Diagnosis (REQUIRED): _____ **Indication:**_____

Date of collection:_____

TEST(S) REQUESTED: □ **Chromosome study (routine)**

□ Acute Myeloid Leukemia (AML) profile

Gene specific probe loci	Structural Chromosome Abnormality	AML subtype
□ ETO/AML1	t(8;21)(q22;q22)	M2
□ PML/RARA	t(15;17)(q22;q21)	M3
□ CBFbeta	inv(16);t(16;16)	M4, Eos
□ 8cen/MYC	+8 (Trisomy 8)	M0-M7
□ DEK/CAN	t(6;9)(p23;q34)	M2, M4, M1
□ EVI1	3q26 rearrangements	M1, 2, 4, 6, 7
□ MLL	11q23 rearrangements	M0-M7

□ B-Cell Acute Lymphoblastic Leukemia (B-ALL) panel

Gene specific probe loci	Structural Chromosome Abnormality
□ TEL/AML1	t(12;21)(p13;q22)
□ BCR/ABL/ASS	t(9;22)(q34;q11.2)
□ PBX1/TCF3	t(1;19)(q23;p13.3)
□ CDKN2A/9cen	-9/9p deletion
□ 4cen	+4
□ 10cen	+10
□ 17cen	+17
□ MLL	11q23 rearrangements

□ Chronic Lymphocytic Leukemia (CLL) panel

Gene specific probe loci	Structural Chromosome Abnormality
□ c-MYB/6cen	-6/6q deletion
□ ATM/11cen	-11/11q deletion
□ 12cen	+12 (Trisomy 12)
□ D13S319/13qter	-13/13q deletion
□ p53/17cen	-17/17p deletion
□ CCND1/IGH	t(11;14)(q13;q32)

□ Chronic Myelogenous Leukemia (CML) FISH test

Gene specific probe loci	Structural Chromosome Abnormality
□ BCR/ABL/ASS	t(9;22)(q34;q11.2)

□ Chronic MyeloMonocytic Leukemia (CMML) panel

Gene specific probe loci	Structural Chromosome Abnormality
□ EGR1/D5S23,D5S721	-5/5q deletion
□ 7cen/D7S486	-7/7q deletion
□ 8cen/myc	+8 (Trisomy 8)
□ D13S319/LAMP1	-13/13q deletion
□ BCR/ABL/ASS	t(9;22)(q34;q11.2)
□ D20S108/D20S150	20q12 deletion

□ Imatinib Mesylate (Gleevec) Responsive Genes profile

Gene specific probe loci	Structural Chromosome Abnormality
□ PDGFRB	5q32-q33
□ FLP1-L1/PDGFRA	4q12
□ BCR/ABL/ASS	t(9;22)(q34;q11.2)

□ Lymphoma profile

Gene specific probe loci	Structural Chromosome Abnormality
□ MYC	8q24 rearrangements
□ MYC/IGH/CEP8	t(8;14)(q24;q32)
□ BCL2/IGH	t(14;18)(q32;q21)
□ BCL6	3q27 rearrangements
□ CCND1/IGH	t(11;14)(q13;q32)
□ MALT1	18q21 rearrangements
□ ***MALT1/IGH**	**t(14;18)(q32;q21)** ***MALT reflex if ordered**

□ Multiple Myeloma (MM)/Plasma Cell Proliferative disorders (PCPD) panel

Gene specific probe loci	Structural Chromosome Abnormality
□ IGH	14q32 rearrangements
□ CCND1/IGH	t(11;14)(q13;q32)
□ p53/17cen	-17/17p deletion
□ D13S319/13qter	-13/13q deletion
□ 9cen/15cen	+9 and +15
□ 3cen/7cen	+3 and +7

□ Myelodysplastic syndrome (MDS) profile

Gene specific probe loci	Structural Chromosome Abnormality
□ EGR1/D5S23,D5S721	-5/5q deletion
□ 7cen/D7S486	-7/7q deletion
□ 8cen/MYC	+8 (Trisomy 8)
□ D13S319/13qter	-13/13qdeletion
□ D20S108/D20S150	-20/20q deletion/idic(20q)
□ EVI1	3q26 rearrangements

□ T-Cell Lymphoma panel

Gene specific probe loci	Structural Chromosome Abnormality
□ BCR/ABL/ASS	t(9;22)(q34;q11.2)
□ 7cen/D7S486	-7/7q deletion
□ 8cen/MYC	+8 (Trisomy 8)
□ MLL	11q23 rearrangements
□ CDKN2A/9cen	-9/9p deletion
□ TRA/D	14q11 rearrangements

□ Other Hematologic tests

Gene specific probe loci	Structural Chromosome Abnormality
□ MYB	6q23
□ MYC	8q24 rearrangements
□ p53	17p13 deletion
□ FLP1-L1/PDGFRA	4q12 rearrangements/tri-color rearrangements
□ BCR/ABL/ASS	t(9;22)(q34;q11.2)
□ MLL	11q23 rearrangements

□ Sex mismatched bone marrow transplant
□ Other gene/locus chromosome anomalies (please specify):

*****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: