MOLECULAR (DNA) TEST REQUISITION

Center for Human Genetics, Inc.
Riverside Technology Center
840 Memorial Drive, Suite 101
Cambridge, MA 02139
Co-directors: Aubrey Milunsky, M.D., D.Sc., Jeff Milunsky, M.D.
Phone: 617-492-7083 Fax: 617-492-7092
Website: http://www.chginc.org

FOR **CHG** LAB USE ONLY:
Date received: _____
Pedigree #: _____
Family name: _____
Sample type: _____
Lab #: _____

Patient Name: _____ □ **Male** □ **Female** □ **Unknown**
Last First

Hospital/Patient ID#: _____ **Date of Birth:** _____

Address: _____ Partner/Parent of: _____

_____ Phone: _____
City State Zip Code

Referring Provider: **NPI #:** _____ **Referring Laboratory (if different):**

Physician signature: _____

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____
City State Zip Code City State Zip Code

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Genetic Counselor: _____ Email: _____

Phone: _____ Fax: _____

Email: _____

**** Billing information (Page 4) and copy of insurance card (front and back) MUST accompany sample and requisition form. ****
**** Consent form (Page 5) is REQUIRED for all samples from New York and all predictive testing BEFORE testing can be initiated.****

CLINICAL INFORMATION:

Ethnicity: □ Ashkenazi Jewish □ French Canadian □ Caucasian □ African American □ Asian □ Hispanic
□ Sephardic Jewish □ Armenian □ Turkish □ Mediterranean □ Arabic □ Other: _____

ICD-10 Diagnosis (REQUIRED): _____

Purpose of Study:

□ Diagnosis
_____
_____
_____

□ Carrier Screen □ Prenatal Diagnosis □ Predictive/Presymptomatic**
□ No family history (Call before sending samples)
□ Family history* □ Ultrasound abnormality*

*Please include additional information: _____

_____

Pregnancy information (if applicable): Gestational age _____ □ By LMP _____ □ By ultrasound _____
Date Date

Name and relationship of family members previously tested at CHG: _____

Name of mutation to be tested (if known in family): _____

MOLECULAR (DNA) TEST REQUISITION

FOR **CHG** LAB USE ONLY:
Pedigree #: Lab #:

Patient Name: _____ **Date of Birth**:_____
Last First

****SPECIMEN REQUIREMENTS FOR ALL TESTS LISTED BELOW: 7-10 cc BLOOD IN EDTA OR ACD ANTICOAGULANT****

DNA TEST(S) REQUESTED:
(PLEASE NOTE: ANALYSIS = SEQUENCING AND MLPA)

Date Sample Collected: _____

- □ Aarskog Scott syndrome (***FGD1*** analysis)
- □ ***ACTG2*** sequencing
- □ Acute Myeloid (Myelogenous) Leukemia
  □ ***FLT3*** D835 mutation □ ***NPM1*** exon 12 sequencing
- □ ***ADGRG2*** sequencing
- □ Alpha-thalassemia/XLID syndrome (***ATRX*** analysis)
- □ Aneurysm osteoarthritis syndrome (***SMAD3*** analysis)
- □ Angelman/Angelman-like syndrome panel
  - □ Methylation-sensitive MLPA
  - Sequencing of □ ***UBE3A*** □ ***SLC9A6***
  - Analysis of □ ***TCF4*** □ ***ZEB2***
- □ Aortic valve disease (***NOTCH1*** sequencing)
- □ ***ARX*** analysis
- □ Ashkenazi Jewish panel
  - □ Bloom syndrome
  - □ Canavan disease
  - □ Factor XI deficiency
  - □ Familial Dysautonomia
  - □ Familial Hyperinsulinemia
  - □ Fanconi anemia Group C
  - □ Gaucher disease
  - □ GSD Type 1A
  - □ Joubert disease
  - □ LDD/DLD
  - □ MSUD Type 1B
  - □ Mucolipidosis type IV
  - □ Nemaline Myopathy
  - □ Niemann-Pick disease Type A
  - □ Tay Sachs disease
  - □ Usher syndrome 1F
  - □ Usher syndrome 3A
  - □ Walker-Warburg syndrome
- □ Ataxia panel
  - □ Spinocerebellar ataxia (check all that apply)
    Types □ 1 □ 2 □ 3 □ 6 □ 7 □ 8 □ 10 □12 □17
  - □ DRPLA
- □ Autism/Autism Spectrum Disorder (53 gene panel)
- □ Autism (with macrocephaly)
  (***PTEN*** analysis and promoter sequencing)
- □ Banking (circle type) DNA or Lymphoblast
- □ Beals syndrome (***FBN2*** sequencing)
- □ Borjesen-Forssman-Lehmann syndrome (***PHF6*** sequencing)
- □ Branchio-oculo-facial syndrome (***TFAP2A*** analysis)
- □ Breast/Ovarian Cancer**
  - □ ***BRCA1/2*** analysis
  - □ ***BRCA1/2*** *(Ashkenazi Jewish mutations only)*
- □ ***C9orf72*** -Related Neurodegenerative Disease
- □ CADASIL (***NOTCH3*** sequencing)
- □ Cardiofaciocutaneous syndrome panel
  Sequencing of □ ***BRAF*** □ ***MAP2K1*** □ ***MAP2K2*** □ ***KRAS***
- □ Charcot-Marie-Tooth disease 1A/HNPP (***PMP22*** MLPA)
- □ Charcot-Marie-Tooth disease 1B, 2I, 2J (***MPZ*** analysis)
- □ CHARGE syndrome (***CHD7*** analysis)
- □ Chronic Intestinal Pseudo-obstruction (***ACTG2*** sequencing)
- □ Coffin-Lowry syndrome (***RSK2*** analysis)
- □ Colon Cancer
  - □ Familial Adenomatous Polyposis (***APC*** analysis)
  - □ Lynch/HNPCC Panel
    Analysis of □ ***MLH1*** □ ***MSH2*** □ ***MSH6*** □ ***PMS2***
    □ ***EPCAM/TACSTD1*** MLPA
  - □ ***MYH*** Associated Polyposis (***MUTYH*** analysis)
- □ Congenital bilateral absence of vas deferens (CBAVD)
  □ 100+ mutations panel □ ***CFTR*** analysis □ ***ADGRG2*** sequencing
- □ Congenital Contractural Arachnodactyly (***FBN2*** sequencing)
- □ CONNECT1 (Connective Tissue Disorders analysis)
  - □ CONNECT1 Sequencing Only (22 genes)
  - □ CONNECT1 MLPA (circle tests)
    COL1A1, COL1A2, COL2A1, COL3A1, COL5A1, COL11A1, FBN1, FLNA , ***MYH11*** , ***SMAD3*** , ***TGFβ2*** , ***TGFβR1*** , ***TGFβR2***
- □ Costello syndrome panel
  Sequencing of □ ***HRAS*** □ ***KRAS*** □ ***BRAF***
- □ Creatine (transporter) deficiency (***SLC6A8*** analysis)
- □ Cystic fibrosis
  - □ 40+ mutations panel □ 100+ mutations panel
  - □ ***CFTR*** analysis
- □ Deafness
  - □ Connexin 26 sequencing (nonsyndromic deafness)
  - □ Connexin 30 deletion (nonsyndromic deafness)
  - □ Mitochondrial A1555G
- □ Developmental Language Disorders
  Sequencing of □ ***FOXP1*** □ ***FOXP2***
- □ Dravet syndrome (***SCN1A*** analysis)
- □ Duchenne or Becker Muscular Dystrophy (***DMD/BMD*** MLPA)
- □ Ehlers-Danlos syndrome
  Types I/II: □ ***COL5A1*** analysis □ ***COL5A2*** sequencing
  Type IV: □ ***COL3A1*** analysis
  Type VII: Analysis of □ ***COL1A1*** □ ***COL1A2***
- □ Ehlers-Danlos variant with periventricular heterotopia (***FLNA*** analysis)
- □ Epilepsy/Intellectual Disability (Female Restricted) (***PCDH19*** analysis)
- □ Familial Mediterranean Fever
  □ Common mutations only □ ***MEFV*** analysis
- □ FG syndrome
  □ ***MED12*** sequencing □ ***FLNA*** analysis
- □ Fragile X syndrome
- □ Hemochromatosis
- □ Huntington disease**
- □ Infantile Spasms
  Analysis of □ ***ARX*** □ ***CDKL5*** □ ***SCN1A***
- □ Infertility testing
  - □ Ovarian insufficiency/spermatogenic failure (***NR5A1*** analysis)
  - □ Premature ovarian failure (Fragile X testing)
  - □ ***SYCP3*** sequencing
  - □ Y-microdeletion studies
- □ Intracranial aneurysm
  Sequencing of □ ***NTM*** □ ***TGFβR3***
- □ Kabuki syndrome
  Analysis of □ ***MLL2/KMT2D*** □ ***KDM6A***
- □ Kennedy disease (***SBMA***)
- □ LADD syndrome
  Analysis of □ ***FGF10*** □ ***FGFR2***
  Sequencing of □ ***FGFR3***
- □ LEOPARD syndrome panel
  Sequencing of □ ***PTPN11*** □ ***RAF1*** □ ***BRAF***
- □ Loeys-Dietz syndrome
  Analysis of □ ***TGFβR1*** □ ***TGFβR2*** □ ***SMAD3*** □ ***TGFβ2***
  Sequencing of □ ***TGFβ3***
- □ Marfan syndrome (***FBN1*** analysis)
- □ Maternal cell contamination studies
- □ ***MED12*** related disorders (***MED12*** sequencing)
- □ Melanoma (***CDKN2A*** analysis)
- □ Mitochondrial diseases panel
  □ All 37 gene analysis □ MELAS □ CPEO/KSS
  □ LHON □ Leigh syndrome/NARP □ MERRF
- □ Mowat Wilson syndrome (***ZEB2*** analysis)
- □ Multiple Endocrine Neoplasia, type 1 (***MEN1*** analysis)
- □ Multiple Endocrine Neoplasia, type 2 (***RET*** analysis)

** Consent form is REQUIRED prior to the initiation of testing.

MOLECULAR (DNA) TEST REQUISITION

FOR **CHG** LAB USE ONLY:

Pedigree #: Lab #:

Patient Name: _____ **Date of Birth**: _____

Last First

****SPECIMEN REQUIREMENTS FOR ALL TESTS LISTED BELOW: 7-10 cc BLOOD IN EDTA OR ACD ANTICOAGULANT****

DNA TEST(S) REQUESTED:
(PLEASE NOTE: ANALYSIS = SEQUENCING AND MLPA)

Date Sample Collected: _____

- □ Myeloproliferative Disease
  - □ ***JAK2*** (V617F mutation [reflex to exon 12 sequencing])
  - □ ***CALR*** exon 9 sequencing
  - □ ***MPL*** sequencing
- □ Neurexin 1 (***NRXN1*** analysis)
- □ Neurofibromatosis
  Analysis of □ ***NF1*** □ ***NF2***
- □ Neurofibromatosis type 1-like (Legius) syndrome
  (***SPRED1*** analysis)
- □ Neuroligin
  Sequencing of □ ***NLGN3*** □ ***NLGN4***
- □ Noonan syndrome panel
  Sequencing of □ ***PTPN11*** □ ***SOS1*** □ ***SOS2*** □ ***RAF1***
  □ ***KRAS*** □ ***NRAS*** □ ***SHOC2*** S2G mutation
  □ ***BRAF*** □ ***CBL*** □ ***RIT1*** □ ***LZTR1***
- □ OpitzG/BBB syndrome (***MID1*** analysis)
- □ Osteogenesis imperfecta Type I, II, III, IV
  Analysis of □ ***COL1A1*** □ ***COL1A2***
- □ Pancreatitis (hereditary)
  - □ Pancreatitis panel: □ ***CTRC*** sequencing,
    Analysis of □ ***PRSS1*** □ ***SPINK1***
  - □ ***CFTR*** analysis
- □ Paraganglioma-Pheochromocytoma syndromes
  Analysis of □ ***SDHB*** □ ***SDHC*** □ ***SDHD***
- □ Paternity testing (Call before sending samples)
- □ Pelizaeus-Merzbacher disease (***PLP1*** analysis)
- □ Pendred syndrome (***SLC26A4*** sequencing)
- □ Phosphomannomutase 2 (***PMM2*** sequencing)
- □ Phenylketonuria (***PAH*** analysis)
- □ Pitt Hopkins syndrome (***TCF4*** analysis)
- □ Pitt Hopkins-like syndrome
  □ ***CNTNAP2*** sequencing □ Neurexin 1 (***NRXN1*** analysis)
- □ Prader-Willi syndrome (Methylation-sensitive MLPA)
- □ ***PTCHD1*** analysis
- □ ***PTEN*** Hamartoma Tumor syndromes
  (***PTEN*** analysis and promoter sequencing)
- □ Renpenning syndrome (***PQBP1*** analysis)
- □ Rett/Rett-like syndrome panel
  Analysis of □ ***MECP2*** □ ***CDKL5*** □ ***FOXG1*** □ ***TCF4***
- □ ***SCN1A*** analysis
- □ Sickle cell anemia (HbSS, HbSC)
- □ Small fiber neuropathy (***SCN9A*** sequencing)
- □ Smith-Lemli-Opitz syndrome (***DHCR7*** sequencing)
- □ SNP microarray
- □ Sotos syndrome (***NSD1*** analysis)
- □ Spinal Muscular Atrophy (***SMN1*** exons 7-8 MLPA)
- □ Stickler syndrome
  Type I: □ ***COL2A1*** analysis
  Type II: □ ***COL11A1*** analysis
  Type III: □ ***COL11A2*** sequencing
- □ ***SYNGAP1*** sequencing
  (Intellectual disability, dominant, nonsyndromic)
- □ Tay-Sachs disease
- □ Thoracic Aortic Aneurysms/Dissections panel
  Analysis of □ ***FBN1*** □ ***MYH11*** □ ***SMAD3***
  □ ***TGFβ2*** □ ***TGFβR1*** □ ***TGFβR2***
  Sequencing of □ ***ACTA2*** □ ***BGN*** □ ***FOXE3*** □ ***LOX*** □ ***MAT2A***
  □ ***MFAP5*** □ ***MYLK*** □ ***NTM*** □ ***PRKG1*** □ ***SKI***
  □ ***SLC2A10*** □ ***SMAD2*** □ ***SMAD6*** □ ***TGFβ3***
- □ Thrombophilia panel
  □ Factor V Leiden (R506Q) □ MTHFR (665C>T; 1286A>C)
  □ Prothrombin (G20210A)
- □ Tuberous Sclerosis
  Analysis of □ ***TSC1*** □ ***TSC2***
- □ UPD: (circle test) chromosome 7 14 15
- □ Visceral Myopathy (***ACTG2*** sequencing)
- □ von-Hippel-Lindau disease (***VHL*** analysis)
- □ Waardenburg syndrome
  Types 1 and 3: □ ***PAX3*** analysis
  Type 2: Analysis of □ ***MITF*** □ ***SOX10***
  Type 4: Analysis of □ ***SOX10*** □ ***EDN3*** □ ***EDNRB***
- □ Wilson disease (***ATP7B*** analysis)
- □ X-inactivation studies
- □ X-linked lymphoproliferative disease (***SH2D1A*** analysis)
- □ X-linked Intellectual Disability (XLID)
  (Order whole panel, individual tiers, or single gene)
  - □ Tier A □ ***NLGN3*** sequencing
    □ ***NLGN4*** sequencing
    □ Rett syndrome (***MECP2*** analysis)
    □ Rett syndrome - atypical (***CDKL5*** analysis)
  - □ Tier 1 □ ***DLG3*** sequencing
    □ ***FTSJ1*** sequencing
    □ ***JARID1C*** sequencing
    □ Borjesen-Forssman-Lehmann syndrome
    (***PHF6*** sequencing)
    □ ***ZNF41*** sequencing
  - □ Tier 2 □ Asperger syndrome (***GDI1*** analysis)
    □ ***FACL4*** analysis
    □ ***OPHN1*** analysis
    □ Renpenning syndrome (***PQBP1*** analysis)
    □ ***TM4SF2 /TSPAN7*** analysis
  - □ Tier 3 □ Alpha-thalassemia/XLID syndrome
    (***ATRX*** analysis)
    □ Aarskog Scott syndrome (***FGD1*** analysis)
    □ OpitzG/BBB syndrome (***MID1*** analysis)
    □ Pelizaeus-Merzbacher disease(***PLP1*** analysis)
    □ Coffin-Lowry syndrome (***RSK2*** analysis)
    □ Creatine (transporter) deficiency
    (***SLC6A8*** analysis)
  - □ Tier 4 □ ***AGTR2*** analysis
    □ ***ARHGEF6*** analysis
    □ ***MED12*** sequencing
    □ ***PAK3*** analysis
    □ ***SLC16A2*** sequencing
  - □ Other X-linked intellectual disability genes
    □ ***IL1RAPL1*** analysis
    □ ***RAB39B*** sequencing
- □ X-linked Intellectual Disability/Epilepsy Panels
  - □ Panel 1 □ Angelman-like syndrome (X-linked
    Christianson type) (***SLC9A6*** sequencing)
    □ ***PCDH19*** sequencing (females only)
    □ Rett syndrome (***MECP2*** analysis)
    □ Rett syndrome - atypical (***CDKL5*** analysis)
  - □ Panel 2 □ ***ATP6AP2*** sequencing
    □ Creatine (transporter) deficiency
    (***SLC6A8*** analysis)
    □ ***OPHN1*** analysis
    □ ***SYN1*** sequencing
- □ XY Disorders of sex development (***NR5A1*** analysis)
- □ Y-microdeletion studies/Y-chromosome detection (SRY)
- □ Zygosity testing

MOLECULAR (DNA) TEST REQUISITION
Center for Human Genetics, Inc.
Riverside Technology Center
840 Memorial Drive, Suite 101
Cambridge, MA 02139
Co-directors: Aubrey Milunsky, M.D., D.Sc., Jeff Milunsky, M.D.
Phone: (617) 492-7083 Fax: (617) 492-7092
Web: http://www.CHGINC.org

Patient Name: _____ **Date of Birth**: _____
Last First MI

INFORMED CONSENT FOR DNA TESTING

**** A signed consent form is REQUIRED for all samples from New York and all predictive testing BEFORE testing can be initiated.**
**** A signed consent form is strongly recommended for all genetic testing. If a signed consent is not submitted, the Center for Human Genetics assumes that the ordering physician has appropriately reviewed and obtained the patient's informed consent.**

I/We request and authorize the DNA Diagnostic Laboratory at the Center for Human Genetics, Inc. to analyze a sample of DNA isolated from _____ (sample type) obtained on _____ (date) to assess the probability that I (my/our fetus/child) am (is) affected with or carry the gene for the genetic disease _____ which is _____ _____.

The test procedure has been explained to me/us and I/we understand that:

I. There are several possible outcomes of this test:
1. The test results may indicate that it is likely or unlikely that I (my/our fetus/child) am (is) affected with, or a carrier for, the above disease.
2. The test results may be indeterminate because of my (my/our fetus'/child's) genetic patterns or the genetic patterns of my family members (if also tested), and/or the limitations of the current technology.

II. DNA tests are performed with precision and results reflect great accuracy and specific degrees of quoted accuracy (when applicable). Turn-around time is estimated and cannot be guaranteed.

III. One possible result of DNA testing is that the laboratory could discover evidence of previously undisclosed non-paternity when comparing my (my/our fetus'/child's) sample with samples from other family members.

IV. Genetic counseling, further testing, or additional physician consults may be warranted after testing in order to complete the testing process.

V. After the DNA testing of my (my/our fetus'/child's) sample is complete, DNA will be stored at the Center for Human Genetics, Inc. for a minimum of three months. **We do not guarantee the future availability of DNA unless specific arrangements have been made for DNA banking.** After that time, any remaining material will be disposed of at the discretion of the Laboratory Director, and may be used for medical research or education so long as our privacy is maintained.

I can request that remaining DNA not be used for research purposes by initialing here: _____

VI. The results of this test are to be released only to the ordering physician and referral laboratory (if applicable) per HIPAA regulations.

My/our signature(s) below constitute(s) my/our acknowledgement (1) that the proposed DNA test(s) and its/their limitations for my/our specific situation have been satisfactorily explained to me/us by my/our physician or genetic counselor; and (2) I/we hereby give my/our authorization and consent for this testing.

_____ _____
Patient/Guardian Signature Witness Signature

_____
Date

*****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: