

REQUISITION FORM

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Please complete all information below.
Failure to do so may delay sample processing.
We accept samples Monday through Saturday.

2820 North Astor Street, Spokane, WA 99207
Phone: 509.474.6840 / Fax: 509.474.6839
TOLL FREE 1.877.SigChip (744.2447)
www.signaturegenomics.com / info@signaturegenomics.com



INFORMED CONSENT REQUIRED

NOTE TO HEALTH CARE PROVIDERS: Signature Genomics recognizes that it is important for physicians to discuss pertinent information about genetic testing with their patients. In accordance with Washington State Law RCW 7.70.050 and WAC 388-531-0050, the physician referring the patient for laboratory testing is responsible for informing the patient of the risks and benefits of the laboratory testing and obtaining the patient's informed consent. As a courtesy to our ordering health care providers and their patients, we offer educational literature including *Points to Consider*, *Frequently Asked Questions for Physicians*, *Frequently Asked Questions for Patients*, and *Informed Consent for Molecular Cytogenetic Testing* to assist in discussions of the benefits and limitations of array CGH testing. To obtain copies of these documents and other helpful resources, please visit our website at www.signaturegenomics.com or contact us directly at 1.877.SigChip (1.877.744.2447).

By signing below, I attest that I have obtained informed consent for the test(s) that I have ordered below through Signature Genomics from this patient and/or guardian(s).

PHYSICIAN SIGNATURE: _____ *Required for samples originating in New York*

PATIENT INFORMATION

DOB ____ / ____ / ____ Male Female Sex Unknown
mm dd yyyy
Last Name _____
First Name _____ M.I. _____
Address _____
City, State, ZIP _____
Home (____) _____ Work (____) _____
Specimen # / ID # _____

REFERRING PHYSICIAN

Name _____
NPI# _____ Specialty _____
Address _____
City, State, ZIP _____
Hospital/Institution _____
Tel (____) _____ FAX (____) _____
Counselor/Contact _____
Tel (____) _____ FAX (____) _____
Address _____
City, State, ZIP _____
Email _____

Additional Reports To:

Name _____
Hospital/Institution _____
Address _____
City, State, ZIP _____
Tel (____) _____ FAX (____) _____

INDICATION FOR STUDY (IFS)

I. IFS
Check all that apply and attach or provide additional details below:
 Developmental Delay (315.9) Dysmorphic Features (796.4)
 Seizure Disorder (345.9) Multiple Congenital Anomalies (759.7)
 Other Autism Spectrum Disorder (299.0)
Provide additional details: _____
II. ICD-9 code (required for insurance billing) _____
III. Karyotype Normal Abnormal Pending Not Performed
Details _____ (attach report)

SAMPLE INFORMATION

Indicate the reference lab sending sample to Signature Genomics:

Date Sample Obtained ____ / ____ / ____ (mm dd yyyy)
 Peripheral blood
 Transformed lymphoblasts
 Placental tissue / Products of conception
Specify tissue of origin _____
 Skin biopsy
 DNA. Please specify source _____
Please read *DNA Acceptance Policy* at www.signaturegenomics.com
 Other. Please specify _____

Specimen Requirements

Additional costs may be incurred if specimen quality or quantity is suboptimal.
Peripheral blood for aCGH: 2 tubes, 1x 3-5cc NaHep and 1x 3-5cc EDTA
Peripheral blood for Karyotype or FISH: 5cc, 1x NaHep
Cultured cells: 1x T-75 flask or 3x T-25 flasks, 70% confluent
Tissue/POC: 15-20mg tissue in sterile media or saline
Skin Biopsy: 3mm x 3mm biopsy in sterile media or saline
DNA: 10ug at a concentration of ~100ng/μL

TEST REQUESTED

SignatureChipOS™ (Oligo Solution)
 Single/Dual FISH _____ Indicate locus to be tested.
 Karyotype
 Fragile X

PARENTS' SAMPLES

Check one. Please note that charges may apply.
 Submitted simultaneously to proband's sample.
 Submitted after proband's analysis, due to abnormal result. Perform follow-up analysis on parental sample(s). If Signature Genomics is to bill a new insurance, please fill out page 2 of this form.
Sample(s) included in this shipment:
 Mother
Name _____ DOB ____ / ____ / ____
Sample Type: Blood DNA other _____
 Father
Name _____ DOB ____ / ____ / ____
Sample Type: Blood DNA other _____

USE OF SPECIMENS

Signature Genomics (SG) retains patient samples indefinitely for validation, educational purposes and/or research, maintaining the confidentiality of each sample. Patients may decline the use of submitted sample(s) for research; refusal does not impact diagnostic testing or reporting of results. Patients may withdraw consent for use of sample(s) at any time by contacting the SG Chief Medical Officer at (509) 474-6840. SG will not pay royalties to patients if a commercial product is developed during research using their samples. I do not wish to allow my (or my child's) sample to be used for test validation or education. Therefore, I am checking this box to indicate that the sample should be used for the test specified above and will be destroyed after 60 days.

SEE PAGE 2 TO COMPLETE BILLING INFORMATION

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PATIENT INFORMATION

DOB ____/____/____ (mm dd yyyy)
Name _____
Last First

INSTITUTIONAL BILLING

P.O. _____
Client ID _____
Institution Name _____
Financial Contact _____
Address _____
City, State, ZIP _____
TEL (____) _____ FAX (____) _____

SELF-PAY

Check or Money Order Credit Card
 Send receipt to patient address on Page 1
Payment will not be processed before sample arrives. This is to ensure that the correct amount is charged to the credit card.
Check one: AMEX Visa MC Discover
Acct # _____ Exp Date ____/____ (mm / yyyy)
Zip Code _____ 3 or 4 Digit Security Code _____
Print Name as it appears on card _____
Signature _____ Date ____/____/____ (mm dd yyyy)
A new authorization and/or signature may be required when testing additional family members.

REQUEST FOR SIGNATURE GENOMICS TO DIRECTLY BILL PATIENT'S INSURANCE

IMPORTANT: Patients and health care providers requesting that Signature Genomics bill private insurance must complete this portion of the requisition form prior to or at the time of sample submission. **Failure to do so will delay testing and results.**

I have obtained prior authorization. **CPT codes and units authorized:** _____
Prior-Authorization #: _____

As a courtesy service, Signature Genomics will obtain benefit information from the patient's insurance. If a benefit investigation and/or prior authorization is requested prior to sample submission, complete and fax both page 1 and page 2 of this requisition form to 509.474.6839. This information may also be submitted with the sample. Please include a Letter of Medical Necessity and clinic notes as this information may be required by the insurance company for prior authorization. For benefit investigation of parents' sample(s), please complete an additional billing page if one parent's insurance differs from the proband's insurance.

Whom should our billing specialist contact in order to communicate benefit information?
CHECK ALL THAT APPLY (REQUIRED): Patient Physician Genetic Counselor/Contact

INSURANCE INFORMATION **Include enlarged copy of insurance card/s (front and back)**

If your institution's intake form addresses all items below, you may attach it. Otherwise, please fill in each item completely.
Is this a Medicaid Policy? Yes No
Insurance Company Name _____
Policyholder's Name _____ Insurance Company Phone _____
Last First M.I.
Plan Name _____
SSN _____ ID# _____
Policyholder's Date of Birth ____/____/____ mm dd yyyy
Group# _____
Relationship to Patient: _____ If HMO, provide PCP Name _____

AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR MY ACCOUNT

I assign and authorize insurance payments to Signature Genomics. I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, medical necessity or otherwise. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State and Federal law. A duplicate or faxed copy of this authorization is considered same as the original document.

AUTHORIZATION TO CONTACT HEALTH INSURANCE CARRIER AND RELEASE CONFIDENTIAL MEDICAL INFORMATION

I understand Signature Genomics will contact my insurance carrier regarding coverage of genetic testing. I authorize the disclosure of insurance benefit coverage and payment information to Signature Genomics. I authorize my physician or other medical entity to release confidential medical information to Signature Genomics concerning my medical history. I authorize Signature Genomics to release confidential medical information to my health insurance carrier to facilitate reimbursement of my medical fees.

Check this box to hold testing until investigation of benefits / prior authorization is complete.
If this box is not checked, analysis will proceed upon sample receipt.

Signature of Patient or Guardian _____ Printed Name of Patient or Guardian _____ Date _____

PATIENT FINANCIAL ASSISTANCE

FINANCIAL ASSISTANCE INFORMATION. For more information, visit our website at www.signaturegenomics.com.

Household size (e.g. number of people): _____ Household income (monthly): _____
By signing below, I certify that the household size and income information shown above is correct. Copies of tax returns, pay stubs and other information verifying income may be required before a discount is applied.
Signature of Patient or Guardian _____ Date _____

Please fax completed forms to **509.474.6839** and include in sample shipment.