

Carrier Screening Test Requisition (January 2010)

Prior to sending prenatal samples, please contact our genetic counseling services.

***Indicates required information**

PATIENT

TESTS

Commercially Insured Patient Information

Complete this requisition for all patients with commercial insurance.¹ Patients with a commercial insurance plan for which Athena is a contracted provider are subject to any co-insurance and deductible of their plan. Patients with a commercial insurance plan for which Athena is not a contracted provider but who have diagnostic testing (including genetic testing where applicable) as a defined benefit on their insurance plan may, in certain States², participate in Athena's Patient Protection Plan, which limits their financial exposure to 20% of the price of the test as long as it is paid before Athena bills the insurance. Athena will bill the patient's insurance for the total price of the test and work on his or her behalf to file all appropriate justifications and/or appeals to maximize the amount paid by the insurance when applicable. Upon receipt of the patient specimen, Athena will contact the patient to gather any missing insurance information, explain the Patient Protection Plan, and obtain the 20% payment mentioned above. If the patient does not choose to participate in the Patient Protection Plan, he or she may be balance billed after billing the insurance and may be responsible for the entire price of the test.

1. Commercial insurance does not include certain Medicare, Medicare HMO, Medicare PPO, Medicaid, or Tricare/Champus, programs for which there is a specific government-mandated billing process. Patients should verify coverage with their individual provider prior to testing. 2. Due to State laws, the Patient Protection Plan is not available in all States.

Patient Identification

Patient Name* _____
First Last

S.S. # _____ Sex: M F Unknown
(circle one)

Ethnicity: Caucasian African American Ashkenazi Jewish
 Hispanic Other _____

DOB* _____ Age* _____

Address* _____
(P.O. Box not acceptable)

City* _____ State* _____ Zip* _____

Phone Day* _____

Phone Evening* _____

Patient ID # (if available) _____

Appeal Authorization: In the event of an underpayment or denial by my insurance carrier, I hereby authorize Athena Diagnostics or their designee, to appeal my health plan on **my behalf**³ to provide the actions and information necessary to overturn the denial or receive reimbursement for the underpaid claim. This authorization shall remain valid until the charges for the orders on this form are paid in full.

Authorization to Release Information and Pay Benefits: I authorize Athena Diagnostics to provide my insurance carrier all information, including test results, concerning my laboratory test(s). I understand that if I choose not to participate in the Patient Protection Plan² I may be responsible for all charges not covered by my insurance carrier within sixty (60) days of claim submission. I authorize and direct that benefits under this claim be paid directly to Athena Diagnostics, and I agree to remit to Athena within thirty (30) days any payment for these services made directly to me. I acknowledge that the charges for the test(s) ordered by my physician will be withdrawn in the event of cancellation only if such cancellation is executed by the ordering physician and a copy of the written confirmation evidencing this action is provided to Athena prior to the issuance of the test result.

2. Due to State laws, the Patient Protection Plan is not available in all States. 3. Athena Diagnostics and/or designee may perform this appeal on my behalf, but is not obligated to do so.

Patient Signature* _____

Date _____

Patient Insurance Information

Please provide a photocopy of the front and back of the insurance card.

Name of Insured* _____
First Last

Relationship to Patient:* Self Parent Spouse Other

Member ID #* _____

Group ID #* _____

Insurance Co. Name* _____

Address* _____

City* _____ State* _____ Zip* _____

Phone _____

Tests Ordered*

- SMA/CF/Fragile X Carrier Screen
- 444 Spinal Muscular Atrophy (SMA) Carrier Screen
- 448 SMA Carrier Plus - **NEW!**
- 446 Cystic Fibrosis Carrier Screen
- 104 Fragile X (FMR1) DNA Test
- 182 Duchenne/Becker Muscular Dystrophy Evaluation - Females
 - 103 Partial DNA Del./Dup. Only Females
 - 185 Familial DNA Sequence Evaluation
- Other (please fill in code from reverse) _____

ICD-9 Code (Required): _____

Indications for Testing (Check One)*

- Prenatal Carrier Predictive Other

Testing Authorization and ICD-9 Code: I warrant that this test is either: 1) for the purpose of diagnosing or detecting an existing disease, illness, impairment, symptom or disorder, or 2) that if it is not for such purpose, I have obtained the appropriate prior written consent. This written consent was signed by the person who is the subject of the test (or if that person lacks capacity to consent, signed by the person authorized to consent for that person), and includes: a) a statement of the purpose and description of the test; b) a statement that prior to signing the consent form, the consenting person discussed with the medical practitioner ordering the test the reliability of positive or negative test results and the level of certainty that a positive test result for that disease or condition serves as a predictor of such disease; c) a statement that the consenting person was informed about the availability and importance of further testing, physician consultation and genetic counseling, and provided with written information identifying a genetic counselor or medical geneticist from whom the consenting person might obtain such counseling; d) a general description of each specific disease or condition tested for; and e) the person or persons to whom the test results may be disclosed as indicated above.

Medical Practitioner Signature* _____ Date _____

PHYSICIAN

Required Physician Information

NPI #* _____ UPIN #* _____

Name* _____
First Last

Address _____

City _____ State _____ Zip _____

Phone* _____ Fax _____

Email* _____

TYPE OF SPECIMEN

- 10ml lavender top tube
- Whole Blood
- CVS: Direct
- CVS: Cultured
- 20ml lavender top tube
- Amniotic Fluid: Direct
- Amniotic Fluid: Cultured

Date Collected* _____

Please Fax this Test Requisition to Access Athena™ at 866-223-1247

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Not all available tests are listed here. Please see our catalog or website for complete offering, as well as CPT codes for each test.

PRENATAL TESTING

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Prenatal Tests

- 444P Spinal Muscular Atrophy
- 215 Complete SMA Evaluation (Reflex)
(SMN1 Del./SMN1 Seq./IGHMBP2 and UBE1)
- 104 Fragile X Syndrome
- 446 Cystic Fibrosis
- 556 Complete Tuberous Sclerosis Evaluation
(TSC1 Seq., TSC1 Del., TSC2 Seq., TSC2 Del.)
- 508 Tuberous Sclerosis TSC1 DNA Deletion Test
- 524 Tuberous Sclerosis TSC2 DNA Deletion Test
- 523 Tuberous Sclerosis Familial Mutation
- 181 Duchenne/Becker Muscular Dystrophy (DMD/BMD) – Males only
 - 101 Partial DMD Del./Dup. only – Males
 - 185 Familial DNA Sequencing
- 108 Myotonic Dystrophy Type 1 (DM1)
- 116 Huntington Disease
- 117 Kennedy Disease
- 721 Nephrotic Syndrome Evaluation
- 131 PMP22 Dup./Del. (CMT1A) DNA Test

Note:

Most tests offered by Athena Diagnostics are available for prenatal testing. Please visit our website at www.athenadiagnostics.com for more testing options.

Athena Diagnostics Client Service Representatives are available from 8:30 a.m. to 6:30 p.m. Eastern Time (US).

Customers in the US and Canada please call toll-free

866-AthenaDx

(866-284-3623)

(Non-US customers please call 508-756-2886 or fax 508-753-5601.)



Testing that Makes a Difference.

Four Biotech Park, 377 Plantation Street
Worcester, MA 01605 • www.AthenaDiagnostics.com

Licensing/Credentials: FID #: 31-1805826, CLIA #: 22D0069726, Medicare #: GE228388
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ADX280SG-1/10KG-REV02

CARRIER/PREDICTIVE TESTING

Most tests require 10ml lavender top tube whole blood

SMA/CF/Fragile X

Neuromuscular Disorders (20ml required)

- 182 Duchenne/Becker Muscular Dystrophy Female Evaluation Dup./Del./Seq.
- 103 Partial DMD – Del./Dup. only – Females
- 183 Partial DMD – Sequencing only

Myotonia

- 126 Complete Myotonic Dystrophy Evaluation (DM1/DM2)

Limb Girdle Muscular Dystrophy

- 562 FKRP DNA Sequencing Test
- 563 Calpain 3 DNA Sequencing Test
- 568 Sarcoglycanopathy (SGCA, B, G, D)
- 565 Lamin A/C DNA Sequencing Test
- 571 Dysferlin DNA Sequencing Test

Motor Neuron Disorders

- 651 Autosomal Dominant HSP Evaluation (SPG3a, SPG4, SPG4/Del., SPG6, SPG8, SPG17, SPG31)
- 652 Autosomal Recessive HSP Evaluation (SPG 7, SPG11)
- 117 Kennedy Disease (SBMA) DNA Test

Epilepsy

- 556 Complete Tuberous Sclerosis Evaluation (TSC1 Seq., TSC1 Del., TSC2 Seq., TSC2 Del.) (20ml required)
- 508 Tuberous Sclerosis TSC1 DNA Deletion Test
- 524 Tuberous Sclerosis TSC2 DNA Deletion Test
- 523 Tuberous Sclerosis Familial Mutation Analysis
- 548 Febrile Seizures Evaluation
- 415 Lafora Disease Evaluation (EPM2A, EPM2B) (20ml required)

Hearing Loss

- 329 Connexin Related Deafness Evaluation (Connexin 26, Connexin 30)

Peripheral Neuropathy

- 143 Cx32 Sequencing/Deletion (CMTX)
- 223 MFN2 DNA Sequencing Test (CMT2A2)
- 134 Myelin Protein Zero DNA Sequencing Test (CMT1B, 2I, 2J)
- 131 PMP22 Dup./Del. (CMT1A) DNA Test

Movement Disorders

- 371 Spinocerebellar Ataxia Type 1 (SCA1)
- 372 Spinocerebellar Ataxia Type 2 (SCA2)
- 105 Spinocerebellar Ataxia Type 3 (SCA3)
- 373 Spinocerebellar Ataxia Type 6 (SCA6)
- 374 Spinocerebellar Ataxia Type 7 (SCA7)
- 388 Spinocerebellar Ataxia Type 17 (SCA17)
- 119 Friedreich Ataxia Evaluation (20ml required)
- 116 Huntington Disease (20ml required)
- 626 Dystonia (DYT1) DNA Test (20ml required)

Parkinsonism

- 540 Parkin DNA Test (20ml required)
- 542 PINK1 DNA Sequencing Test

Nephrotic Syndrome

- 714 LAMB2 DNA Sequencing Test
- 730 NPHS1 DNA Sequencing Test
- 710 NPHS2 DNA Sequencing Test

Other

- 761 PKDx® Sequencing Analysis
- 879 Congenital Adrenal Hyperplasia (CAH)