Athena Endocrinology Test Requisition (October 2011)

***Indicates required information**

Medicare Patients – Please use the Athena Diagnostics Endocrinology Medicare Test Requisition Form.
For a copy, please call Client Services or visit our website: www.AthenaDiagnostics.com/medicare.

Medicaid/Patients Without Insurance – Please complete the patient identification information, and we will contact the patient directly.

Please tear at perforation

PATIENT

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 States,[2] participate in Athena's Patient Protection Plan. Under this plan, the patient's out-of-pocket exposure will be no more than 20% of billed charges or $500, whichever is less. 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 and explain the Patient Protection Plan. if the patient does not choose to participate in the Patient Protection Plan, Athena will still bill their insurance company. However, if the insurance company does not pay the full amount, the patient may be responsible for the balance.

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)

Patient ID # (if available) _____

S.S. # _____ Sex: ☐ Male ☐ Female ☐ Unknown

DOB* _____

Age* _____

Mailing Address* _____

_____

City* _____ State* _____ Zip* _____

Phone #1* _____ ☐ Day ☐ Eve ☐ Cell

Phone #2* _____ ☐ Day ☐ Eve ☐ Cell

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 Plan[2] 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.

STOP Signature Required Here

_____
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 _____

PHYSICIAN

Physician/Laboratory Contact Information

NOTE: Specimen tube(s) must be labeled with two of the following forms of identification: name, date of birth, social security no., patient ID no. These same two forms of ID should also be indicated on the test requisition.

Contact Name _____ (First) _____ (Last)

Phone _____ Fax _____

Email _____

Tests Ordered*

Important: Write in the test code and test name (see list on reverse).

Code _____ Name _____

Code _____ Name _____

ICD-9 Code (Required): _____

Required Physician Information

NPI #* _____ UPIN #* _____

Name* _____ (First) _____ (Last)

Address _____

City _____ State _____ Zip _____

Phone* _____ Fax _____

Email* _____

Additional Authorized Result Report Recipient

Name _____ (First) _____ (Last)

UPIN # or CLIA # _____

Address _____
(P.O. Box not acceptable)

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Indications for Testing (Check One)*

☐ Diagnostic (symptomatic) ☐ Clinical Study ☐ Prenatal
☐ Predictive (asymptomatic) ☐ Carrier ☐ Other Research

Warrant of Informed Consent

Testing Authorization: I warrant that this test was ordered and 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*

Type of Specimen ☐ Whole Blood ☐ Serum Date Collected* _____

NOTE: Specimen tube(s) must be labeled with two of the following forms of identification: name, date of birth, social security no., patient ID no. These same two forms of ID should also be indicated on the test requisition.

**For Athena's Specimen Collection Service*,
Please Fax this Test Requisition to Access Athena™ at 866-223-1247**

*Specimen collection service will work with the patient to obtain phlebotomy services through either a home draw or other laboratory. See online catalog at AthenaDiagnostics.com for complete specifications and shipping information.

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Tests included in multi-test evaluations may be ordered individually.

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Test Code	Test Name	Genes Included

Adrenal Disorders

☐ **816 Primary Adrenal Insufficiency (Addison's disease)** — ABCD1, NR0B1, AIRE

- ☐ 815 ABCD1 DNA Sequencing Test (X-linked Adrenoleukodystrophy)
- ☐ 814 NR0B1/DAX1 DNA Sequencing Test (X-linked Adrenal Hypoplasia Congenita)
- ☐ 881 Endocrine Hypertension (HSD11B2) DNA Sequencing Test (Apparent Mineralocorticoid Excess)
- ☐ 855 PHEX DNA Sequencing Test (X-linked Hypophosphatemic Rickets)
- ☐ 856 FGF23 DNA Sequencing Test (Autosomal Dominant Hypophosphatemic Rickets)

☐ **879 Congenital Adrenal Hyperplasia Evaluation**
CYP21A2 sequencing and deletion, CYP11B1 sequencing

- ☐ 880 CYP21A2 (CAH) DNA Sequencing and Deletion Test

Required: Indication for Study (check one or more below):

- ☐ Family history of CAH
- ☐ Virilization (ambiguous genitalia)
- ☐ Salt Wasting
- ☐ Parent/sibling of CAH patient
- ☐ 17-hydroxyprogesterone (17-OHP) elevated concentration in serum
- ☐ Other_____

- ☐ 875 CYP11B1 (CAH) DNA Sequencing Test

☐ 874 Lipoid CAH (STAR) DNA Sequencing Test
☐ 877 CYP17A1 DNA Sequencing Test
☐ 878 HSD3B2 DNA Sequencing Test
☐ 881 Endocrine Hypertension (HSD11B2) DNA Sequencing Test

Bone Diseases

☐ **860 Osteogenesis Imperfecta Evaluation** — COL1A1, COL1A2

- ☐ 861 COL1A1 (OI) DNA Sequencing Test
- ☐ 862 COL1A2 (OI) DNA Sequencing Test

☐ 811 Osteoporosis-Pseudoglioma (LRP5) DNA Sequencing Test
☐ 821 Idiopathic Osteoporosis (LRP5) DNA Sequencing Test

☐ **857 Hypophosphatemic Rickets Evaluation** — PHEX, FGF23

- ☐ 855 PHEX (Hypophosphatemic Rickets) DNA Sequencing Test
- ☐ 856 FGF23 (Hypophosphatemic Rickets) DNA Sequencing Test

Chromosome Microarray Analysis

☐ **783 180K WholeGenome Chromosomal Microarray Analysis***
☐ **782 60K WholeGenome Chromosomal Microarray Analysis***

WholeGenome Microarray Specimen Requirement:

10 mL whole blood drawn in a lavender top tube (EDTA)
AND
10 mL whole blood drawn in a green top tube
Pediatric minimum: 4 mL in each tube

Indication for Study (MUST check one or more below):

- ☐ Developmental Delay: ☐ Mild ☐ Moderate ☐ Severe
- ☐ Mental Retardation: ☐ Mild ☐ Moderate ☐ Severe
- ☐ Autistic Spectrum
- ☐ Failure to Thrive
- ☐ Multiple Congenital Anomalies
- ☐ Infertility
- ☐ Trisomy 13 ☐ Trisomy 18 ☐ Trisomy 21
- ☐ Dysmorphic Features
- ☐ Fetal Demise ☐ Seizures
- ☐ Klinefelter Syndrome
- ☐ Multiple Miscarriages (#_____)
- ☐ Testicular Failure
- ☐ Turner Syndrome
- ☐ Ambiguous Genitalia
- ☐ Other:_____
- ☐ Family History: _____

Previous Cytogenetic Results (if applicable): _____
Family Members Studied by Athena: _____

Proband Accession #: _____

Test Code	Test Name	Genes Included

NOTE: Athena is a member of the International Standard Cytogenomic Array Consortium (ISCA) and provides de-identified, HIPAA-compliant genomic results to the National Center for Biotechnology Information (NCBI) database. The NCBI is a division of the National Institute of Health (NIH) and serves the mission of advancing our understanding of human genetics. Patients may withdraw consent to use their data by calling 1-800-394-4493 option 2.

Congenital Hyperinsulinism

☐ **819 Congenital Hyperinsulinism Evaluation**
GLUD1, GCK, KCNJ11, ABCC8

Indication for Study (check one or more below):

- ☐ Diazoxide Responsive
- ☐ Diazoxide Non-Responsive
- ☐ Hypoglycemic
- ☐ Large for Gestational Age (LGA)
- ☐ Other (describe) _____

- ☐ 822 GLUD1 (CH) DNA Sequencing Test
- ☐ 823 GCK (CH) DNA Sequencing Test
- ☐ 826 KCNJ11 (CH) DNA Sequencing Test
- ☐ 827 ABCC8 (CH) DNA Sequencing Test

☐ 042 **CH Parental Testing – To augment child/proband diagnosis**

For expedited diagnosis of proband, send parental testing samples as soon as possible and provide information below.

☐ Mother ☐ Father

Proband Name/Accession #_____

Diabetes

Antibody Tests with Reflex to MODY 1, 2, 3

Specimen Requirements: **1 mL serum** drawn in a serum separator or red top
AND
10 mL whole blood drawn in a lavender top (EDTA) tube

- ☐ 806 GAD-65 with Negative Reflex to MODY 1, 2, 3
- ☐ 807 IA-2 with Negative Reflex to MODY 1, 2, 3
- ☐ 808 IAA with Negative Reflex to MODY 1, 2, 3 (exclude if patient has received exogenous insulin)
- ☐ **809 Diabetes Antibody Panel with Negative Reflex to MODY 1, 2, 3**
  Step 1. GAD65, IA-2, and IAA; Step 2. MODY 1, 2, and 3

Antibody Tests Only

Specimen Requirements: 1 mL serum drawn in a serum separator or red top

- ☐ 820 GAD-65
- ☐ 838 IA-2
- ☐ 896 IAA (exclude if patient has received exogenous insulin)
- ☐ **897 Diabetes Antibody Panel**
  GAD65, IA-2, and IAA

☐ **850 Monogenic Diabetes (MODY) Evaluation**
Testing is performed in this order:
1. HNF1A, GCK, HNF4A, HNF1B sequencing and deletion, IPF1 sequencing
2. CEL sequencing

- ☐ 802 HNF4A (MODY1) DNA Sequencing and Deletion Test
- ☐ 803 GCK (MODY2) DNA Sequencing and Deletion Test
- ☐ 804 HNF1A (MODY3) DNA Sequencing and Deletion Test
- ☐ 834 IPF1 (MODY4) DNA Sequencing Test
- ☐ 805 HNF1B (MODY5) DNA Sequencing and Deletion Test
- ☐ 837 CEL (MODY8) DNA Sequencing Test

☐ **882 Neonatal Diabetes Mellitus Evaluation** — IPF1, GCK, KCNJ11, INS, ABCC8

- ☐ 841 IPF1 (NDM) DNA Sequencing Test
- ☐ 842 GCK (NDM) DNA Sequencing Test
- ☐ 843 KCNJ11 (NDM) DNA Sequencing Test
- ☐ 853 INS (NDM) DNA Sequencing Test
- ☐ 876 ABCC8 (NDM) DNA Sequencing Test

Test Code	Test Name	Genes Included
Nephrogenic Diabetes		
☐ **854**	**Nephrogenic Diabetes Insipidus Evaluation**	AVPR2, AQP2
☐ 851	Nephrogenic Diabetes Insipidus (AVPR2) DNA Sequencing Test	
☐ 852	Nephrogenic Diabetes Insipidus (AQP2) DNA Sequencing Test	
Familial Cancer Syndromes		
☐ 818	MEN1 (MEN1) DNA Sequencing Test	
☐ **889**	**Pheochromocytoma Evaluation**	RET, VHL, SDHB
☐ 813	MEN2 (RET) DNA Sequencing Test	
☐ 858	von Hippel-Lindau Syndrome (VHL) DNA Sequencing Test	
☐ 888	SDHB DNA Sequencing Test	
Familial Hypocalciuric Hypercalcemia		
☐ 829	Familial Hypocalciuric Hypercalcemia (CASR) DNA Sequencing Test	
Familial Testing – Targeted Analysis		
☐ **800**	**Familial DNA Sequence Evaluation** This test detects previously identified sequence variants in at-risk family members. This test is available for HNF4A, GCK, TCF1, IPF1, TCF2, COL1A1, COL1A2, MEN1, and RET mutations Proband Accession #_____ Relationship _____	
Lipid Disorders		
☐ **895**	**Hypercholesterolemia Evaluation**	LDLR, APOB
☐ 894	LDLR (Hypercholesterolemia) DNA Sequencing Test	
☐ 893	APOB Mutation Analysis	

The following tests are sendouts to Quest Diagnostics Nichols Institute: GAD-65, IA-2, and IAA.

Test Code	Test Name	Genes Included
Obesity		
☐ **884**	**Early Onset Obesity Panel**	LEPR, MC4R
☐ 883	Early Onset Obesity (LEPR) DNA Sequencing Test	
☐ 640	Early Onset Obesity (MC4R) DNA Sequencing Test	
☐ **887**	**Bardet-Biedl Syndrome Evaluation**	BBS1, BBS2, BBS10
☐ 871	BBS1 (BBS) DNA Sequencing Test	
☐ 872	BBS2 (BBS) DNA Sequencing Test	
☐ 886	BBS10 (BBS) DNA Sequencing Test	
Reproductive Disorders		
☐ 817	Male Precocious Puberty (LHCGR) DNA Sequencing Test	
Short Stature		
☐ **865**	**Combined Pituitary Hormone Deficiency Evaluation**	PROP1, POU1F1
☐ 863	PROP1 (CPHD) DNA Sequencing Test	
☐ 864	POU1F1 (CPHD) DNA Sequencing Test	
☐ 846	Noonan Syndrome (PTPN11) DNA Sequencing Test	
☐ **848**	**Growth Hormone Deficiency (GHD) Evaluation**	GH1 and GHRHR seq.; SHOX seq. and del.
☐ 866	GH1 (GHD) DNA Sequencing Test	
☐ 868	GHRHR (GHD) DNA Sequencing Test	
☐ 847	SHOX (GHD) DNA Sequencing and Deletion Test	
☐ 867	GHR (SS) DNA Sequencing Test	

Testing performed under exclusive license from Correlagen Diagnostics, Inc., www.correlagen.com

Specimen Requirements* & Shipping Information (applies to all tests)

Specimen Type: Whole blood, 10 mL in yellow or lavender top (pediatric minimum volume: 2 mL)
Stability: Hemolysis may compromise DNA recovery and integrity after 48 hrs. Store for short periods only (until shipped) at 4°C.
Shipping: Send specimen overnight at room temperature (must arrive less than 24 hrs after collection). Ship Monday through Thursday only.

*__Please Note:__ As indicated in the test listing, Diabetes Antibody Tests with Reflex to MODY 1, 2, 3 (Test Codes 806, 807, 808, 809) and Diabetes Antibody Tests Only (Test Codes 820, 838, 896, 897) have differing specimen requirements from those indicated above.

NOTE: Specimen tube(s) must be labeled with two of the following forms of identification: name, date of birth, social security no., patient ID no. These same two forms of ID should also be indicated on the test requisition.

Billing Information

Insurance Billing/Patient Protection Plan: Patients with a commercial insurance plan[1] for which Athena is a contracted provider are subject to the deductible and co-insurance obligations of their plan. For these patients, Athena will bill insurance directly for all of our services and there will be no up-front charges paid to Athena by the patient. Athena will forward the appropriate notification of obligation to the patient as specified by the Explanation of Benefits (EOB). In all instances, Athena will adhere to the terms of the patient's individual policy insofar as payments for services are concerned. Patients should check with their local provider for pre-authorization and coverage questions related to our services.

Patients with a commercial insurance plan for which Athena is a contracted provider are subject to any co-insurance and deductible of their plan[1]. 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 States,[2] participate in Athena's Patient Protection Plan. Under this plan, the patient's out-of-pocket exposure will be no more than 20% of billed charges or $500, whichever is less. 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 and explain the Patient Protection Plan. if the patient does not choose to participate in the Patient Protection Plan, Athena will still bill their insurance company. However, if the insurance company does not pay the full amount, the patient may be responsible for the balance.

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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.)

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

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Testing that Makes a Difference.

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