

BMGDL GENETIC TEST REQUISITION FORM

<p>BIOCHEMICAL and MOLECULAR GENETICS DIAGNOSTIC LAB University of Miami, Department of Human Genetics 1501 NW 10th Ave, BRB-535 (M860), Miami, FL 33136 Ph. (305) 243-5450 Fax (305) 243-5451</p> <p>Clients must contact the Genetics Billing Office at (305)-243-6583 to establish a "Client Account Number" prior to forwarding specimens to the laboratory. For specimen pick up, test results, status, and any other technical inquiry, please call the BMGDL at 305-243-5450</p>	<p align="center">CLIENT ACCOUNT INFORMATION</p> <p>Client Name: _____ Fax: _____ Client No.: _____ Tel: _____ Medical Record #: _____ Auth #: _____</p>
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<p>ATTENTION HEALTH CARE PROVIDERS: Medical Necessity: Federal regulators require that only tests that are necessary for diagnosis and treatment of a patient's condition be ordered. ICD-10 Code is required to prove medical necessity of outpatients (please enter ICD-10 code on page 2, top section). Dr.'s name, phone number and ICD-10 Code are absolutely required. PLEASE PRINT ALL OF THE FOLLOWING INFORMATION.</p>	<p align="center">SPECIMEN INFORMATION</p> <p>Collection Date: ____/____/____ Time: ____am/pm Collected By: _____ Specimen Source: _____ Sample type(s) submitted: Green Top tube / Urine container Other: _____ <input type="checkbox"/> STAT <input type="checkbox"/> New Born Screen <input type="checkbox"/> Routine</p>
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<p align="center">PATIENT INFORMATION</p> <p>Last Name: _____ First Name: _____ Address: _____ City: _____ State: _____ Zip: _____ SS#: _____/_____/_____ Date of Birth: ____/____/_____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F ICD-10 Code: _____ Medical Record #: _____</p>	<p><i>For BMGDL use only:</i> Accession No.: _____ Received by: _____ Date: ____/____/_____ Time: ____am/pm Amount of Sample: _____ Condition of Sample: _____</p>
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ORDERING PHYSICIAN INFORMATION (PLEASE PRINT LEGIBLY)

Test Order Date: ____/____/_____
 Time: ____am/pm
 Ordering M.D. Name: _____
 Ordering M.D. NPI #: _____
 Hospital/Lab Name: _____
 Address: _____ City: _____
 State: _____ Zip: _____
 Tel: _____ Fax: _____
Ordering M.D. Signature: _____

PATIENT INSURANCE INFORMATION (IF APPLICABLE)

INSURED: _____ HMO PPO POS
 Insurance Co: _____
 Authorization # (if required) _____
 Medicaid/ Medicare#: _____
 Policy #: _____
 Address: _____ City: _____
 State: _____ Zip: _____
 Tel: _____ Fax: _____
 Relationship to Insured: _____

DUPLICATE REPORT

Physician Genetic Counselor Other
 Last Name: _____ First Name: _____
 Address: _____ City: _____
 State: _____ Zip: _____
 Tel: _____ Fax: _____

PLACE BARCODE/LABELS HERE

For BMGDL use only:

BIOCHEMICAL and MOLECULAR GENETICS DIAGNOSTIC LAB

CPT Codes	Biochemical Genetics Testing	KEY	Check Test Order	CPT Codes	Biochemical Genetics Testing	KEY	Check Test Order
TEST DESCRIPTION				TEST DESCRIPTION			
82017	Acylcarnitines, Plasma (Lab Code 110001)	G		84030	PKU Profile, Plasma (Lab Code 110061)	G	
82139	Amino Acids, Plasma {6 or more amino acids} (Lab Code 110002)	G		82542	Succinic Acetone, Urine (Lab Code 110070)	U	
83921	Methylmalonic Acid, Plasma (Lab Code 110046)	G		82379	Total & Free Carnitine, Plasma (Lab Code 110005)	G	
82136	MSUD profile (Lab Code 110055) {2 to 5 amino acids}	G					
83919	Organic Acids, Urine (Lab Code 110013)	U					

Refer to KEY Column above for specimen collection info. SAMPLE KEY: G= GREEN TOP TUBE (sodium heparin) 2ml at room temperature. U = Urine specimen 3ml refrigerated at 4 degrees C. All Specimens must be collected and provided to laboratory. Refer to BMGDL Compendium for additional detailed information or call the lab. 9-2017

ORDERING PHYSICIAN ASSUMES RESPONSIBILITY FOR OBTAINING APPROPRIATE INFORMED CONSENT FOR GENETIC TESTING

FLAHCA: 800026334	Provider: Dept. Human Genetics	<p>Client Notification: Clients should contact the laboratory prior to shipping any specimen emanating <u>outside of the State of Florida</u>, to determine BMGDL licensing eligibility to accept the sample for testing. For technical assistance, please call (305)-243-5450. Please note that specimens will not be processed until out of State billing functions have been approved and cleared by the UM Genetics Billing Office. Contact (305)-243-6583. Communication may also be completed via email Geneticsbillingoffice@med.miami.edu. 9-2017</p>
CLIA: 10D2031737	External Billing Area:	
Medicare:BS5872	Internal Billing Area:	
Medicaid: 000796000	Tax ID No: 59-0624458 Facility: BMGDL	

Clinical Symptoms (check all that apply)			
<input type="checkbox"/> Hypotonia	<input type="checkbox"/> Hepatopathy	<input type="checkbox"/> Dysmorphic Features	<input type="checkbox"/> Skeletal Abnormalities
<input type="checkbox"/> Seizures	specify.....	specify.....	specify.....
<input type="checkbox"/> Develop. Delay
<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Eye Disease	<input type="checkbox"/> MRI Findings	<input type="checkbox"/> Positive Family History
<input type="checkbox"/> Cardiomyopathy	specify.....	specify.....	specify.....
Biochemical Symptoms (check all that apply)			
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Metabolic Acidosis	<input type="checkbox"/> Special Diet.....	<input type="checkbox"/> Abnormal Newborn Screen
<input type="checkbox"/> Hyperammonemia	<input type="checkbox"/> Metabolic Alkalosis	<input type="checkbox"/> Medications.....	specify.....
<input type="checkbox"/> Increased Anion Gap	<input type="checkbox"/> Elevated CK	
<input type="checkbox"/> Additional Clinical Information / Other Information:			
9-2017			
<input type="checkbox"/> Suspected Diagnosis/ICD-10:		<input type="checkbox"/> Known Diagnosis/ICD-10:	