Atrium Health Wake Forest Baptist

MOLECULAR GENETICS FORM FOR DNA ANALYSIS

Medical Center Boulevard
Winston-Salem, NC 27157
Ph: (336) 716-4321 Fax: (336) 716-2554
https://www.wakehealth.edu/medicalgenetics

PLEASE COMPLETE FULLY AND LEGIBLY

Patient Name *(please print)*: (*Last*)	(*First*)	(*Middle*)	(*Maiden*)	Date of Brith:

Patient Street Address:	City:	State:	ZIP:	Daytime Phone: ( )

Sex: ☐Male ☐Female	Patient's Mother's First Name:	Medical Record Number (MRN):	Hospital:

Statement of Financial Responsibility

I authorize any holder of medical or other information about me to release to my healthcare provider, third party processor, and the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this healthcare encounter or related claim. I permit a copy of this authorization to be used in place of the original and request payment of authorized insurance benefits be made on my behalf to the WFU Physicians. I understand I am responsible for payment of these charges. I am also responsible for payment if my insurance carrier decides this is a non-covered service or requires prior authorization, which I did not obtain.

Patient Signature: **Date:**

Ordering Physician (*Last, First*):	Phone/Pager: ( )	Fax: ( )

Ordering Physician Signature:

Date: **Time:**

BILLING INFORMATION *(attach copies of front and back of all insurance cards)*

Bill: ☐Forsyth Novant ☐Moses Cone Clinical Lab ☐CFMFC ☐Women's Hosp Greensboro Clinical Lab
☐Medicare ☐Medicaid ☐Carolina Access #: _____
☐Insurance Company: _____
Subscriber Name: _____
Relationship to Patient: _____
Policy ID/Number: _____

Employer:	Employer Phone: ( )

SPECIMEN INFORMATION

Specimen Collection Requirements: 5 to 10cc of blood collected in a purple top EDTA tube – room temperature.

Type of Specimen: ☐Blood ☐Bone Marrow ☐Amniotic Fluid ☐Tissue ☐Check Swab ☐Paraffin Block
☐DNA *(must be extracted in a CLIA-accredited lab)*

Collect Date:	**Collect Time:**	Collected by:

SIGNS/SYMPTOMS/INDICATION (ICD-10 CODES) FOR A DNA STUDY

*Check **all** that apply. Codes here do not represent entire listing of ICD-10 codes available; please consult current ICD-10 coding manual for complete listing.*

☐ADHD (F90.2)	☐Developmental delay (F88)	☐Learning delay (F81.9)
☐AML (C92.00)	☐Failure to thrive, child (R62.51)	☐Mod. Intellectual disability (F71)
☐AML in remission (C92.01)	☐Failure to thrive, newborn (P92.6)	☐Multiple congenital anomalies (Q89.7)
☐AML in relapse (C92.02)	☐Hypotonia, cong (P94.2)	☐Obesity unspecified (E66.9)
☐Autism – infantile (F84.0)	☐Lack of coordination (R27.8)	☐Short stature (R62.52)
☐Cystic Fibrosis screening (Z13.228)	☐Language delay (F80.9)	☐Transplant status, BM (Z94.81)

☐Additional Clinical Information/ICD-10 codes (*specify*): _____

TEST(S) REQUESTED

Note: When ordering tests for which Medicare reimbursement is sought, it is recommended that the Provider consult any Local Medical Review Policies (LMRP) or National Coverage Decisions (NCD) that may be applicable to the test(s) being ordered. Based on guidance issued in either of these policies, it may be necessary to obtain an Advanced Beneficiary Notice (ABN) from the Medicare Patient. For Medicaid and other carriers, a signed Statement of Financial Responsibility from the patient may be necessary (see above).

☐Angelman/Prader-Willi (PW) Syndrome (*SNRPN* Methylation)
☐Cystic Fibrosis Genotype (*CFTR*) (specify ethnic background below)
☐Cystic Fibrosis Carrier Screen (specify ethnic background below)
☐Fragile X-associated Tremor/Ataxia Syndrome (*FMR1*)
☐Fragile X Syndrome (*FMR1*)
☐Spinal Muscular Atrophy Screen (*SMN1*)
☐ Spinal Muscular Atrophy Diagnostic (*SMN1/2*)

Ethnic Background (Important for accurate Cystic Fibrosis test interpretation)

☐NW European Caucasian	☐ Mixed European Caucasian	☐Other Jewish	☐Hispanic	☐Native American
☐S European Caucasian	☐Ashkenazi Jewish	☐Asian	☐African American	☐Other *(specify)*: