Nephrology Patient Insurance Test Requisition (August 2014)

Patients Requesting Financial Assistance – Patients who meet certain income guidelines may qualify for financial assistance. Please complete the patient identification information and Athena Diagnostics® will contact the patient directly to initiate the application process and (for patients where insurance remits to patient only) to collect prepayment.

For any patient of any payer (including Medicare and Medicaid) you should only order those tests which are medically necessary for the diagnosis and treatment of the patient.

athena diagnostics®

Fields in red indicate required information

Patient

Insured Patient Information

Complete this requisition for all patients with insurance, including Medicare. Patients with an insurance plan for which Athena Diagnostics is a contracted provider are subject to any co-insurance and deductible of their plan. Athena Diagnostics will bill the patient's insurance for the total price of the test and work on the patient's behalf to file appropriate justifications and/or appeals when applicable. Patients should verify coverage with their health plan prior to testing..

Patient Identification

Patient Name _____ (First) _____ (Last)

Patient ID # (if available) _____

DOB _____ Sex: ☐ Male ☐ Female

Last Four Digits of SS# _____ ☐ Unknown

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 to my insurance carrier on my behalf,[1] 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 I may be responsible for all charges not covered by my insurance carrier, and I understand that payment is due within thirty (30) days of receipt of your invoice. I authorize and direct that benefits under this claim be paid directly to Athena Diagnostics, and I agree to remit to Athena immediately 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.

1. 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

Authorization to Use De-identified Specimen for Research. To promote medical understanding and develop better health insights, Athena Diagnostics requests your permission to use your specimen in a de-identified way (without identifying information) for research, if appropriate. Your name or other personal identifying information will not be used in or linked to the results of any studies and publications. Your refusal to have your specimen used or not used for research purposes will not affect processing or testing of your specimen, your test results or the service support provided by Athena Diagnostics to your physician. Please indicate your approval by checking the box next to **Yes** or denial by checking the box next to **No**.

I consent to the use of my de-identified specimen for research: ☐ **Yes** ☐ **No**

_____

Signature of Patient, Parent or Legally Authorized Representative Date

_____

Printed Name of Patient, Parent or Legally Authorized Representative Date

_____

Relationship to Patient if Signatory is Someone Other than Patient

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

Insurance Co. Name _____

Member ID # _____

Group ID # _____

Address _____

City _____ State _____ Zip _____

Phone _____

Does the patient have secondary insurance? ☐ Yes ☐ No

If yes, please attach face sheet and copy of front and back of insurance card.

Physician

Physician/Laboratory Contact Information

NOTE: Specimen tube(s) must be labeled with two of the following forms of identification: name, date of birth, last four digits of SS#, patient ID no. These same two forms of ID must also 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 Code (Required): _____

Required Physician Information

NPI # _____

Athena Account # (if assigned) _____

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 Genetic Testing (Check One)

☐ Diagnostic (symptomatic) ☐ Prenatal ☐ Family Testing

☐ Predictive (asymptomatic) ☐ Carrier

Physician Attestation of Informed Consent

In accordance with Massachusetts General Law Chapter 111, Section 70G, and New York Civil Rights Law Section 79-1 verification of patient informed consent is required for genetic testing. Additionally, testing laboratories located in Massachusetts require a signed acknowledgement from the ordering medical practitioner. The signed acknowledgement is required to complete the genetic testing ordered if you have not previously signed a blanket Physician Attestation of Informed Consent (PAIC) at any Quest lab. The company offers a blanket PAIC that can be signed for all future orders.

I warrant that I have obtained both oral and written consent using the **Patient Informed Consent Form for Genetic Testing** provided by Athena Diagnostics. 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).

_____

Medical Practitioner Signature Date

_____

Printed Name of Medical Practitioner NPI

Patient Informed Consent Form for Genetic Testing is available at AthenaDiagnostics.com/consent.

Type of Specimen ☐ Whole Blood Date Collected* _____

NOTE: Specimen tube(s) must be labeled with two of the following forms of identification: name, date of birth, last four digits of SS#, patient ID no. These same two forms of ID must be indicated on the test requisition.

For Specimen Collection Service,* Please Fax this Test Requisition to 610-271-6085.

*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.

Note: Test requisitions become outdated. For the most accurate and up-to-date test offering, please visit AthenaDiagnostics.com.

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Important: Please be sure to write in test code and test name in the Tests Ordered section on front.

Test Code		Pref. Spec.	Min. Vol.	Tube Type
Alport Syndrome				
☐	**759 Complete Alport Evaluation** (COL4A3,4,5 DNA Sequencing; COL4A5 Deletion Test)	B	20 mL	L
☐	755 COL4A5 DNA Sequencing and Deletion Test	B	20 mL	L
☐	756 COL4A5 Deletion Test	B	20 mL	L
☐	757 COL4A3 DNA Sequencing Test	B	20 mL	L
☐	758 COL4A4 DNA Sequencing Test	B	20 mL	L
Amyloidosis				
☐	235 Amyloidosis Evaluation (TTR)	B	20 mL	L
Bardet-Biedl Syndrome				
☐	**887 Bardet-Biedl Syndrome Evaluation** (BBS1, BBS2, BBS10)	B	10 mL	L
☐	871 BBS1 (BBS) DNA Sequencing Test	B	10 mL	L
☐	872 BBS2 (BBS) DNA Sequencing Test	B	10 mL	L
☐	886 BBS10 (BBS) DNA Sequencing Test	B	10 mL	L
Fanconi Syndrome				
☐	517 MELAS mtDNA Evaluation (MELAS 3243, 3271, 3252, 3256, 3291, 13513)	B	20 mL	L
Family Testing				
☐	**185 Familial DNA Sequence Evaluation** This test detects previously identified sequence variants in at-risk family members. Proband Accession # _____ Relationship _____	B	10 mL	L
Hereditary Renal Tubular Disorders				
☐	**767 Hereditary Renal Tubular Disorders Evaluation** (SLC12A1, KCNJ1, CLCNKB, BSND, SLC12A3)	B	10 mL	L
☐	762 SLC12A1 DNA Sequencing Test (Bartter type 1)	B	10 mL	L
☐	763 KCNJ1 DNA Sequencing Test (Bartter type 2)	B	10 mL	L
☐	764 CLCNKB DNA Sequencing Test (Bartter type 3)	B	10 mL	L
☐	765 BSND DNA Sequencing Test (Bartter type 4)	B	10 mL	L
☐	766 SLC12A3 DNA Sequencing Test (Gitelman)	B	10 mL	L
☐	825 Autosomal Dominant Hypocalcemia (CASR) Evaluation	B	10 mL	L
Monogenic Hypertension				
☐	**749 Monogenic Hypertension Evaluation** (SCNN1B, SCNN1G, CYP11B1, HSD11B2)	B	10 mL	L
☐	747 Liddle's Syndrome Evaluation (SCNN1B, SCNN1G)	B	10 mL	L
☐	748 Pseudohypoaldosteronism Type 1 Evaluation (SCNN1A, SCNN1B, SCNN1G)	B	10 mL	L
☐	772 SCNN1A DNA Sequencing Test	B	10 mL	L
☐	745 SCNN1B DNA Sequencing Test	B	10 mL	L
☐	746 SCNN1G DNA Sequencing Test	B	10 mL	L
☐	774 CYP11B1 DNA Sequencing. Test	B	10 mL	L
☐	775 HSD11B2 DNA Sequencing Test	B	10 mL	L
☐	779 CYP11B1/CYP11B2 Chimeric Gene Fusion Test	B	10 mL	L
Nephrogenic Diabetes Insipidus				
☐	**854 Nephrogenic Diabetes Insipidus Evaluation** (AVPR2, AQP2)	B	10 mL	L
☐	851 AVPR2 DNA Sequencing Test	B	10 mL	L
☐	852 AQP2 DNA Sequencing Test	B	10 mL	L
Nephronophthisis				
☐	750 NPH1 (Familial Juvenile Nephronophthisis (FJN)) Molecular Test	B	10 mL	L

Test Code		Pref. Spec.	Min. Vol.	Tube Type
Nephrotic Syndrome				
☐	**722 Early Onset Nephrotic Syndrome Evaluation** (PLCE1, LAMB2, WT1, NPHS1, NPHS2)	B	10 mL	L
☐	**717 Inherited Focal and Segmental Glomerulosclerosis (FSGS) Evaluation** (INF2, ACTN4, TRPC6, NPHS2)	B	10 mL	L
☐	711 ACTN4 DNA Sequencing Test	B	10 mL	L
☐	712 TRPC6 DNA Sequencing Test	B	10 mL	L
☐	716 INF2 DNA Sequencing Test	B	10 mL	L
☐	718 PLCE1 DNA Sequencing Test	B	10 mL	L
☐	713 WT1 DNA Sequencing Test	B	10 mL	L
☐	714 LAMB2 DNA Sequencing Test	B	10 mL	L
☐	710 NPHS2 DNA Sequencing Test (Steroid Resistant Nephrotic Syndrome; Podocin)	B	10 mL	L
☐	730 NPHS1 DNA Sequencing Test (Congenital Nephrotic Syndrome; Nephrin)	B	10 mL	L
Polycystic Kidney Disease				
☐	**761 Complete PKD Evaluation** Step 1. PKD1/PKD2 Sequencing; Step 2. PKD1/PKD2 MLPA			
☐	725 PKDx® DNA Sequencing Test (PKD1 and PKD2 Sequencing)	B	10 mL	L
☐	728 PKDx® Familial Mutation Evaluation (PKD1 and PKD2 Single Exon Sequencing) Proband Accession # _____ Relationship _____	B	10 mL	L
☐	760 PKD Del. Test (PKD1/PKD2 MLPA)	B	10 mL	L
Other Cystic Diseases				
☐	**556 Complete Tuberous Sclerosis Evaluation** (TSC1 Sequencing, TSC1 Deletion, TSC2 Sequencing, TSC2 Deletion)	B	20 mL	L
☐	521 TSC1 DNA Sequencing Test	B	20 mL	L
☐	508 TSC1 DNA Deletion Test	B	20 mL	L
☐	522 TSC2 DNA Sequencing Test	B	20 mL	L
☐	523 TSC Familial Mutation Evaluation (TSC1 and TSC2 Single Exon Sequencing) Proband Accession # _____ Relationship _____	B	10 mL	L
☐	524 TSC2 DNA Deletion Test	B	10 mL	L
☐	770 Hereditary Interstitial Kidney Disease (2 exon UMOD seq.)	B	10 mL	L
☐	836 TCF2 DNA Sequencing Test (Renal Cysts and Diabetes Syndrome (RCAD))	B	10 mL	L
Renal Cancer				
☐	**889 Pheochromocytoma Evaluation** (RET, VHL, SDHB)	B	10 mL	L
☐	813 MEN2 (RET) Evaluation	B	10 mL	L
☐	818 MEN1 (MEN1) Evaluation	B	10 mL	L
☐	888 SDHB DNA Sequencing Test	B	10 mL	L
☐	858 von Hippel-Lindau Syndrome (VHL) Evaluation	B	10 mL	L
Renal Cysts and Diabetes				
☐	776 HNF1ß DNA Sequencing and Deletion Evaluation (RCAD)	B	10 mL	L
Rickets				
☐	**857 Hypophosphatemic Rickets Evaluation** (PHEX, FGF23)	B	10 mL	L
☐	855 PHEX DNA Seq. Test (X-linked Hypophosphatemic Rickets)	B	10 mL	L
☐	856 FGF23 DNA Sequencing Test (Autosomal Dominant Hypophosphatemic Rickets)	B	10 mL	L

Specimen Requirements & Shipping Information

Specimen Type: B – Blood

Tube Type: L – Lavender

Pediatric Minimum Volume: 2 mL (for blood tests)

Stability: Hemolysis may compromise DNA recovery and integrity after 48 hrs. It is recommended to ship samples immediately after draw. Samples can be stored for short periods only. Send specimen overnight at room temperature.

Shipping: Send specimen overnight at room temperature. If you have any questions on sample requirements or shipping, contact our client service department at 800-394-4493, extension 2.

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

Billing Information

Patients with a commercial insurance plan[1] for which Athena is a contracted provider are subject to any co-insurance and deductible of their plan. Athena will bill the patient's insurance for the total price of the test and work on their behalf to file appropriate justifications and/or appeals when applicable. Patients should verify coverage with their health plan prior to testing.

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.

For Specimen Collection Service,* Please Fax this Test Requisition to 610-271-6085.

*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.

Athena Diagnostics, Inc., 200 Forest Street, 2nd Floor, Marlborough, MA 01752 • AthenaDiagnostics.com • 800-394-4493

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