Insurance and Advance Pay Test Requisition

athena diagnostics

For Specimen Collection Service, Please Fax this Test Requisition to 1.610.271.6085

Client Services is available Monday through Friday from 8:30 AM to 9:00 PM EST at 1.800.394.4493, option 2

Patient Information

Patient Name _____

Patient ID# (if available) _____

Date of Birth _____ Sex designated at birth: ☐ Male ☐ Female

Street address _____

City, State, Zip _____

Mobile phone #1 _____ Other Phone #2 _____

Patient email _____

Language spoken if other than English _____

Ordering Account Information

Ordering physician name: _____

Address _____

City, State, Zip _____

Phone _____ Fax _____ Email _____

NPI# _____ Athena Account # (if assigned) _____

Reporting preference: ☐ Fax ☐ Email

Send additional report copies to:

Clinician/Facility _____

NPI# or CLIA _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Email _____

Test Information

Consult test list for test code, name and acceptable specimen options. Specimen requirements are referenced at the top of the test list.
Call Client Services at 1.800.394.4493, option 2 for additional details.

ICD-10 Codes (required for billing insurance): _____

Test Code	Test Name

Clinical Information

Clinical diagnosis: _____

Age at Initial Presentation: _____

Ancestral Background (check all that apply):

☐ African ☐ Asian: East ☐ Asian: Southeast ☐ Central/South American
☐ Hispanic ☐ Native American ☐ Ashkenazi Jewish ☐ Asian: Indian
☐ Caribbean ☐ European ☐ Middle Eastern ☐ Pacific Islander

Other: _____

Indications for genetic testing (please check one):

☐ Diagnostic (symptomatic) ☐ Predictive (asymptomatic) ☐ Prenatal (Contact Athena prior to sending)
☐ Carrier ☐ Family testing/single site

Relationship to Proband: _____

If performed at Athena, provide relative's accession #_____.

If performed at another lab, a copy of the relative's report is required.

Please attach detailed medical records and family history information.

Specimen Information

Specimen Type: Date sample obtained: _____/_____/_____

☐ Whole Blood ☐ Serum ☐ Cerebrospinal Fluid (CSF) ☐ CVS: Cultured
☐ Amniotic Fluid: Cultured ☐ Saliva (Not available for all tests)

☐ DNA* source: _____Concentration _____ ug/ml

*DNA must be extracted at a CLIA-certified or a laboratory meeting equivalent requirements (as determined by CAP and/or CMS).

☐ Other** source (provide specimen type): _____

Contact Athena **prior to sending specimen types not listed above.

If not collected same day as shipped, how was sample stored? ☐ Room temp ☐ Refrigerated ☐ Frozen

History of ☐ blood transfusion or ☐ bone marrow transplant? ☐ Yes ☐ No

Date of most recent transfusion/transplant: _____/_____/_____

Statement of Medical Necessity and 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 acknowledgment from the ordering medical practitioner. The signed acknowledgment 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.

Prior to ordering genetic testing on the patient listed above, I have obtained a signed, written consent form from the patient (or their authorized representative) as required by applicable state law and/or regulations, and I will maintain all written consent forms as part of the patient file and make them available to Athena Diagnostics upon reasonable request. Many payers (including Medicare and Medicaid) have medical necessity requirements consistent with local state regulatory requirements for the test ordered. I understand I should only order those tests which are medically necessary for the diagnosis and treatment of the patient consistent with local state regulatory requirements for the test ordered. I further confirm this test is medically necessary for the diagnosis or detection of disease, illness, impairment, symptom, syndrome, or disorder and the results will be used in the medical management and treatment decisions for the patient consistent with local state regulatory requirements for the test ordered. I confirm that the person listed in the Ordering Physician space above is authorized by law to order the test(s) requested herein consistent with local state regulatory requirements for the test ordered.

Please sign, date and include your credentialed (MD, DO, NP) to document your intent to order the testing. Please note that if the information is not provided, you may be required to provide medical records and/or progress notes to support intent to order on payor request.

Medical Practitioner Signature: _____ Date _____/_____/_____

Medical Practitioner Credentials:_____