athena diagnostics

Reset Form

Insurance and Advance Pay Test Requisition (2021)

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 _____

Test and Specimen Information

Consult test list for test code and name

Test Code: _____ Test Name: _____

Test Code: _____ Test Name: _____

☐ Check if more than 2 tests are ordered. Additional tests should be checked off within the test list

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

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* ☐ 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 Type: Date sample obtained: _____/_____/_____

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

☐ DNA** - tissue source: _____ Concentration _____ ug/ml

Was DNA extracted at a CLIA-certified laboratory or a laboratory meeting equivalent requirements (as determined by CAP and/or CMS)? ☐ Yes ☐ No

☐ Other*: _____

If not collected same day as shipped, how was sample stored? ☐ Room temp ☐ Refrigerated ☐ Frozen (-20) ☐ Frozen (-80)

History of blood transfusion? ☐ Yes ☐ No Most recent transfusion: _____/_____/_____

*Please contact us at 1.800.394.4493, option 2 prior to sending specimens.

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

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 _____

Statement of Medical Necessity and Informed Consent:

I have provided information to the patient regarding tests ordered and the patient and/or his/her legal guardian has given consent for tests ordered. Many payers (including Medicare and Medicaid) have medical necessity requirements. I understand I should only order those tests which are medically necessary for the diagnosis and treatment of the patient. 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. I confirm that the person listed in the Ordering Physician space above is authorized by law to order the test(s) requested herein.

Medical Practitioner Signature: _____ Date _____/_____/_____

NOTE: Athena offers a blanket Physician Attestation of Informed Consent that can be signed and applied to all future orders.

Please select the payment option:

☐ Insurance (fill in **Insurance Pay Option** below) ☐ Advance Pay (fill in **Advance Pay Option** below)

Please see Page 2 for Billing/Payment Options. **Please see Page 3 for test list.**

Payment Options: To be completed by the Patient

Please check the preferred payment option and complete the corresponding section.

For Billing inquiries' provide contact information.

Name: _____

Mobile Phone (includes texts) _____ Email _____

☐ **Option 1: Insurance Pay** *(Please provide a photocopy of the front and back of ALL insurance cards, including secondary)*

Name of Insured: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Insurance Company: _____ Member ID# _____ Group ID# _____

Does the patient have secondary insurance? ☐ Yes ☐ No

Insurance Company: _____ Member ID# _____ Group ID# _____

Referral/Prior authorization # (please attach referral/authorization): _____

☐ **Option 1A: Athena Alliance Program (AAP)* Patient Assistance**

Please see the Athena Website for further information about the AAP offering (https://www.athenadiagnostics.com/insurance-billing/athena-alliance-program)

To expedite consideration for AAP eligibility, please provide the number of household members _____ and the annual income** of your household $ _____ .

*AAP not available for Advance Pay/self-paying clients.

**Annual household income includes the income of tax filer (if any), their spouse or partner, and their dependents with income.

If you do not qualify for AAP and you do not want to have insurance billed, CHECK HERE ☐ to place order on hold to have discussion about test cost and Advance Pay. Please see the Advance Pay Section.

NOTE: Athena Diagnostics does not hold Immunology test codes.

Patient Acknowledgement

I hereby acknowledge that the above information is true and correct to the best of my knowledge. I also authorize the release of any and all financial records necessary to verify the above information. I hereby acknowledge that I am neither related to nor employed by the physician who ordered the testing. The contact information above will be used to communicate with me unless I provide alternative information. For more detailed information on the AAP program or to complete and send an AAP application separately, go to www.athenadiagnostics.com. For Medicaid and Medicare beneficiaries, payment is required prior to genetic testing. I understand that if my physician ordered genetic testing and I have Medicare an Advanced Beneficiary Notice (ABN) is required prior to the test proceeding. I authorize Athena Diagnostics to release information received, including, without limitation, medical information, which includes laboratory test results, to my health plan/insurance carrier and its authorized representatives as necessary for reimbursement. I further authorize my health plan/insurance carrier to directly pay Athena for the services rendered. I understand that I may be responsible for portions of this test not covered by my insurance if I do not qualify for and submit AAP application.

☐ I am a New York Resident and I give Athena Diagnostics permission to store my sample for longer than 60 days.

Signature of Patient/Responsible Party: _____ Date _____

☐ **Option 2: Advance Pay** **Only available for genetic testing**

I do not wish for this testing to be submitted for reimbursement to my health insurance plan and am electing to be treated as a self-pay patient for this testing. If I have insurance coverage, I acknowledge and agree Athena Diagnostics will not submit a claim to my insurance for this testing or provide me with information that may be needed by the health insurance plan for a claim.

By agreeing to Advance Pay, I understand that I will be receiving a 20% discount off the cost of this test. I acknowledge that if I fail to pay the amount due within 30 days of Athena receiving my sample, I will be charged the full cost of testing unless I qualify for AAP.

Signature of Patient/Responsible Party: _____ Date: _____ Amount*: _____

*Call Athena Diagnostics at 1.800.394.4493, option 4 for Advance Pay price. By selecting this option, I agree to pay the full Advance Pay amount within 30 Days of specimen receipt.

Patient plans to pay by: ☐ Check (Payable to Athena Diagnostics) ☐ Credit Card (Please call 1.800.394.4493, option 4 to make a payment with credit card).

In test codes that have multiple phases (reflexive components), there is a chance for the patient to receive a subsequent bill if the test result meets the criteria to reflex/move to the next phase. By electing the Advance Pay Option you will still receive the 20% discount on the reflexive component of the ordered test. For questions on whether or not the ordered test code is reflexive, please call 1.800.394.4493, option 4.

A valid email address or mobile telephone number is required for Advance Pay participation. By providing an email address and/or mobile telephone number, the patient consents to receive calls, emails and/or text messages to collect payment (normal message and data rates may apply). The messages will not include test information or results. For more information, the patient may call 1.800.394.4493, option 4.

Mobile Phone: _____ Email: _____