



BRACAnalysis®

Test Request Form and Statement of Medical Necessity

ENTIRE FORM MUST BE COMPLETED TO AVOID DELAYS

SPECIMEN COLLECTION DATE (REQUIRED)

03/24/2008

MYRIAD GENETIC LABORATORIES, INC.
A CLIA Certified Laboratory
320 Wakara Way • Salt Lake City, Utah 84108
(800) 469-7423 • (801) 584-1100
Fax (801) 584-3615 • info@myriad.com

NOTE: Affix Bar Code Labels to Specimen Tubes.

ORDERING PHYSICIAN				SEND RESULTS TO (IF OTHER THAN ORDERING PHYSICIAN)			
NAME (LAST, FIRST, DEGREE) Brown, Bob, MD		NPI# 3456789012		NAME (LAST, FIRST, DEGREE)		NPI#	
MYRIAD ACCOUNT NO: (If new customer or account number is unknown, please complete the address info or call (800) 469-7423) 12345				MYRIAD ACCOUNT NO: (If new customer or account number is unknown, please complete the address info or call (800) 469-7423)			
ADDRESS		CITY STATE ZIP		ADDRESS		CITY STATE ZIP	
OFFICE CONTACT Shirley Tate		PHONE 222-222-2222		OFFICE CONTACT		PHONE	
PATIENT INFORMATION							
PATIENT NAME (LAST, FIRST, INITIAL) Doe, Jane T			PATIENT ID# 123-45-6789		<input checked="" type="checkbox"/> FEMALE <input type="checkbox"/> MALE	BIRTH DATE (MM/DD/YYYY) 09/10/1954	
STREET ADDRESS 123 Generic Street		CITY This City	STATE ST	ZIP 45678	DAYTIME PHONE NUMBER 222-000-0000	ALTERNATE PHONE NUMBER	
ANCESTRY AND CLINICAL HISTORY							
<input type="checkbox"/> WESTERN/NORTHERN EUROPE	<input checked="" type="checkbox"/> CENTRAL/EASTERN EUROPE	<input type="checkbox"/> AFRICA	<input type="checkbox"/> NEAR EAST/MIDDLE EAST	<input type="checkbox"/> OTHER			
<input type="checkbox"/> ASHKENAZI	<input type="checkbox"/> LATIN AMERICAN/CARIBBEAN	<input type="checkbox"/> ASIA	<input type="checkbox"/> NATIVE AMERICAN				
PATIENT HISTORY OF CANCER (CHECK ALL THAT APPLY)				FAMILY HISTORY OF CANCER <i>Please Indicate Relationship, Site of Cancer, Age at Diagnosis.</i>			
ICD-9 CODE(S)/Dx: 174.9, v16.3				<input type="checkbox"/> NO KNOWN FAMILY HISTORY			
<input type="checkbox"/> NO PERSONAL HISTORY OF CANCER	<input checked="" type="checkbox"/> BREAST, INVASIVE/AGE AT Dx: 46	<input type="checkbox"/> BILATERAL	RELATIONSHIP Paternal aunt	CANCER SITE Breast	AGE AT Dx 44		
<input type="checkbox"/> BREAST, DCIS/AGE AT Dx: _____	<input type="checkbox"/> BILATERAL	RELATIONSHIP _____	CANCER SITE _____	AGE AT Dx _____			
<input type="checkbox"/> OVARY/AGE AT Dx: _____	RELATIONSHIP _____	CANCER SITE _____	AGE AT Dx _____				
<input type="checkbox"/> OTHER: _____	AGE AT Dx: _____	RELATIONSHIP _____	CANCER SITE _____	AGE AT Dx _____			
TESTS REQUESTED							
<input checked="" type="checkbox"/> Comprehensive BRACAnalysis®—BRCA1 and BRCA2 gene analysis for susceptibility to breast and ovarian cancer.							
<input type="checkbox"/> Multisite 3 BRACAnalysis®—Three-mutation BRCA1 and BRCA2 analysis for individuals of Ashkenazi Jewish ancestry (187delAG, 5385insC, 6174delT)							
<input type="checkbox"/> REFLEX to a Comprehensive BRACAnalysis® if the Multisite 3 is negative.	<input type="checkbox"/> Check here if a family member is positive for one of the above three mutations.						
<input type="checkbox"/> Single Site BRACAnalysis®—Mutation-specific analysis for individuals with known BRCA1 or BRCA2 mutations in their family. Specify Gene: <input type="checkbox"/> BRCA1 <input type="checkbox"/> BRCA2							
<input type="checkbox"/> Specify Variant (Mutation): _____	Relationship of known mutation carrier to patient (e.g., sister): _____						
<input type="checkbox"/> Other: _____							
INFORMED CONSENT AND STATEMENT OF MEDICAL NECESSITY							
I have supplied information to the patient regarding genetic testing and the patient has given consent for genetic testing to be performed. I further confirm that this test is medically necessary for the diagnosis or detection of a disease, illness, impairment, 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 field above is authorized by law to order the test(s) requested herein.							
(NOTE: For Medicare patients, please complete the enclosed Informed Consent Form)							
(NOTE: Test requests without a signature will not be processed)							
SIGN & DATE Bob Brown, MD						03/24/2008	
Medical Professional Signature						Date	
BILLING/PAYMENT INFORMATION							
<input checked="" type="checkbox"/> OPTION 1: PLEASE BILL MY INSURANCE Option 1 requires patient signature and enlarged copy of both sides of insurance card(s). If two cards are submitted, indicate which is primary.							
Name of Insured: Jane T. Doe		DOB: 09/10/1954		Insurance ID#/ SSN#: 123-45-6789		(Please attach copy of authorization/referral)	
Patient Relationship to Insured: <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Authorization/Referral #: _____					
I hereby authorize Myriad Genetic Laboratories, Inc. (MGL) to furnish my designated insurance carrier, health plan, or third party administrator (collectively "Plan") the information on this form and other information provided by my health care provider if necessary for reimbursement. I also authorize a benefits of the plan to be payable to MGL. I understand that I am responsible for any amount not paid by my Plan for reasons including, but not limited to, covered and non-authorized services. I understand that if I am responsible for more than \$375 co-insurance (excluding unmet deductibles), Myriad will bill me prior to releasing the test. I permit a copy of this authorization to be used in place of the original.							
SIGN & DATE Jane T. Doe						03/24/2008	
Patient/Responsible Party Signature: _____						Date: _____	
<input type="checkbox"/> OPTION 2: PATIENT PAYMENT (Please call Customer Service for questions regarding test prices.)							
<input type="checkbox"/> Please bill my credit card (all major credit cards accepted) in the amount of \$ _____ Card# _____ Exp. Date: _____							
Cardholder Name (please print): _____				Cardholder Signature: _____			
<input type="checkbox"/> Personal check, cashiers check, or money order enclosed, payable to Myriad Genetic Laboratories, Inc.							
<input type="checkbox"/> OPTION 3: OTHER BILLING							
<input type="checkbox"/> Bill our institutional account # _____ (to establish an account, submit billing information with this form). Established research project code #: _____							
<input type="checkbox"/> Myriad has authorized research testing for this patient. "MGA" number assigned: _____							