



# 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) <b>Brown, Bob, MD</b>		NPI# <b>3456789012</b>		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) <b>12345</b>				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 <b>Shirley Tate</b>		PHONE <b>222-222-2222</b>		OFFICE CONTACT		PHONE			
PATIENT INFORMATION									
PATIENT NAME (LAST, FIRST, INITIAL) <b>Doe, Jane T</b>				PATIENT ID# <b>123-45-6789</b>		<input checked="" type="checkbox"/> FEMALE <input type="checkbox"/> MALE		BIRTH DATE (MM/DD/YYYY) <b>09/10/1954</b>	
STREET ADDRESS <b>123 Generic Street</b>		CITY <b>This City</b>	STATE <b>ST</b>	ZIP <b>45678</b>	DAYTIME PHONE NUMBER <b>222-000-0000</b>		ALTERNATE PHONE NUMBER		
ANCESTRY AND CLINICAL HISTORY									
<input type="checkbox"/> WESTERN/NORTHERN EUROPE <input type="checkbox"/> ASHKENAZI		<input checked="" type="checkbox"/> CENTRAL/EASTERN EUROPE <input type="checkbox"/> LATIN AMERICAN/CARIBBEAN		<input type="checkbox"/> AFRICA <input type="checkbox"/> ASIA		<input type="checkbox"/> NEAR EAST/MIDDLE EAST <input type="checkbox"/> NATIVE AMERICAN		<input type="checkbox"/> OTHER	
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: <b>174.9, v16.3</b>					<input type="checkbox"/> NO KNOWN FAMILY HISTORY				
<input type="checkbox"/> NO PERSONAL HISTORY OF CANCER					RELATIONSHIP <b>Paternal aunt</b> CANCER SITE <b>Breast</b> AGE AT Dx <b>44</b>				
<input checked="" type="checkbox"/> BREAST, INVASIVE/AGE AT Dx: <b>46</b> <input type="checkbox"/> BILATERAL					RELATIONSHIP _____      CANCER SITE _____      AGE AT Dx _____				
<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 <b>Bob Brown, MD</b>								<b>03/24/2008</b>	
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: <b>Jane T. Doe</b> DOB: <b>09/10/1954</b> Insurance ID#/ SSN#: <b>123-45-6789</b>									
Patient Relationship to Insured: <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other      Authorization/Referral #: _____ (Please attach copy of 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 <b>Jane T. Doe</b>								<b>03/24/2008</b>	
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: _____									

REMINDER: INCLUDE A COPY OF BOTH SIDES OF YOUR INSURANCE CARD(S)