

MOLECULAR ONCOLOGY REQUISITION

FOR CLIENT USE ONLY Requisition Date: _____		
Completed by: _____	Phone: _____	Accn#: _____

FOR UIDL USE ONLY UIDL Accn#: _____		
UIDL MRN#: _____		

PART A – PATIENT INFORMATION – <i>Required</i>		
Patient Name: _____		
Street: _____		
City: _____	St: _____	Zip: _____
Phone: () _____		
Date of Birth: _____	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	

PART B – PROVIDER INFORMATION – <i>Required</i>		
Referring Facility: _____		
Street: _____		
City: _____	St: _____	Zip: _____
Phone: () _____	Fax: () _____	
Referring Physician: _____		
Referring Physician Phone/Fax: _____		
Genetic Counselor: _____	Phone: _____	

PART C – SPECIMEN INFORMATION (Complete the appropriate information below.)

SPECIMEN COLLECTION DATE: _____ SPECIMEN COLLECTION TIME: _____

Specimens & Materials Submitted: <input type="checkbox"/> Whole Blood (EDTA) <input type="checkbox"/> Plasma <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Lymph Node Aspirate	<input type="checkbox"/> TISSUE BLOCKS # of Blocks: _____ # of Slides: _____ <input type="checkbox"/> SLIDES Tissue Source: _____ <input type="checkbox"/> Other (<i>specify</i>): _____	NOTE: Include <u>1 H & E</u> stained slide and <u>10 unstained</u> slides with each paraffin block.
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Required ICD-9 codes: 1. _____ 2. _____ 3. _____

This order for molecular diagnostic tests from UI Diagnostic Laboratories certifies the ordering physician obtained informed consent from the patient required by state or federal laws for each test ordered and has patient authorization permitting UIDL to report results for each test ordered to the ordering physician.

Genetic Counseling and Information: By requesting testing, the ordering physician assumes responsibility for providing the patient with all associated guidance and counseling regarding the test results. Alternatively, patients can be referred to qualified counseling services by contacting Client Services at (866) 844-2522.

MOLECULAR ONCOLOGY TEST MENU

<input type="checkbox"/> FLT-3/NPM1 Mutation Detection	<input type="checkbox"/> JAK2 V617F Mutation Detection
<input type="checkbox"/> bcl-2 PCR Assay for Lymphoma	<input type="checkbox"/> KRAS Mutational Analysis - codons 12, 13, and 61 (19 mutations)
<input type="checkbox"/> BRAF Mutation Analysis	<input type="checkbox"/> Microsatellite Instability - submit tumor and normal tissue, please
<input type="checkbox"/> EGFR Sequencing (exons 18-21)	<input type="checkbox"/> TCRG Clonality by PCR
<input type="checkbox"/> IGH Gene Clonality by PCR	<input type="checkbox"/> OTHER: _____

Refer to the UIDL TEST DIRECTORY for specimen requirements and CPT Codes at www.healthcare.uiowa.edu/uidl.

PART D - SEND BILL TO:	<input type="checkbox"/> Referring Institution - Billing Contact Person: _____ Phone: _____ <input type="checkbox"/> Patient's Insurance (Complete billing information must be provided or referring institution may be billed)
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Primary Insurance Coverage Information Insured by: _____ Claims Address: _____ City: _____ ST: _____ ZIP: _____ Policy/ID #: _____ Group #: _____ Name of Subscriber: _____ DOB: _____ Relationship to Patient: _____	Secondary Insurance Coverage Information Insured by: _____ Claims Address: _____ City: _____ ST: _____ Zip: _____ Policy/ID #: _____ Group #: _____ Name of Subscriber: _____ DOB: _____ Relationship to Patient: _____
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Please note that the **correct birth date of all policy holders** is required information. Please attach the following to the requisition:
 (1) a copy of the front/back of patient's insurance card(s). Please designate primary vs. secondary/tertiary coverage, **OR**
 (2) a printout with patient demographics and insurance information from your practice management system.

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.