Machaon Diagnostics

Familial Genetic Testing Form

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Routine Turnaround Time: 1 week

MachaonDiagnostics.com
1-800-566-3462

PATIENT INFORMATION (complete or attach)		**SUBMITTING FACILITY**	
Patient's Name: (Last, First, M.I.) *required*	Sex: *required* ◯ M ◯ F	Facility Name and Address: *required*	
Specimen Date and Time: *required*	DOB: (MM/DD/YYYY) *required*		
MRN: *required*	Accession #:	Facility Phone Number: *required*	Fax Number for Results: *required*

ORDERING PHYSICIAN INFORMATION		**BILLING INFORMATION**	
Physician's Name: (Last, First, M.I.) *required*	Physician's NPI:	**Bill to: ☐ Facility (Inpatient or Outpatient)**	
Genetic Counselor's Name: (Last, First, M.I.)	Fax Number for Results:	**Bill to: ☐ Insurance (Outpatient)**	Please call to speak with our Patient Advocates about insurance coverage
Direct Physician/Counselor Number to Call Results (ENCOURAGED):		**Familial genetic testing is generally performed on first-degree relatives, which include biological parents, siblings, and children of patients**	

TEST SELECTION

SPECIMEN REQUIREMENT: 3 mL EDTA whole blood, room temperature. See website for full details.

Please attach previous genetic testing results **If additional space is needed to list targets of interest, please attach additional pages**	☐ Familial Gene Sequencing Panel – List panel(s):
	☐ Individual Gene Sequencing – List gene(s):
	☐ Sanger Sequencing – List target(s):
Targets for Sanger Sequencing MUST be provided using one of the formats listed to the right	(1) transcript plus cDNA change (e.g., NM_000552.5:c.2365A>G) (2) genome build plus genomic coordinate (e.g., GRCh37 chr12 g.6153534T>C) (3) reference SNP number (e.g., rs1063856) Please include the protein change, if applicable (e.g., p.Thr789Ala)

OUTPATIENT ONLY: INSURANCE BILLING INFORMATION (complete or attach)

Insurance Company: (***Medicare patients must sign ABN***)			Patient Address:	Patient Phone Number:
Insurance Policy / Medicare Number:	Insurance Group Number:		Patient City:	State: / Zip Code:
Insurance Company Address:	Authorization Number:			
Insurance Company City:	State:	Zip Code:		

DIAGNOSIS CODE(S):		**Please complete medical necessity form**
ICD-10 Code:	ICD-10 Code:	ICD-10 Code:

OUTPATIENT ONLY: PATIENT SIGNATURE

Machaon Diagnostics may need to obtain additional information from your physician to complete these services. I hereby authorize the release of medical information related to the services described herein and authorize payment directly to Machaon Diagnostics. I agree to assume responsibility for payment of all charges not covered by my healthcare insurer.

Patient's Signature:

X:_____Date:_____

ADDITIONAL INFORMATION

Machaon Diagnostics is a specialized coagulation and platelet laboratory that provides comprehensive clinical evaluations of bleeding and clotting patients. Most evaluations can be completed within 24 hours, 7 days a week. Machaon Diagnostics is a multi-state-licensed, CLIA-accredited, CAP-accredited, clinical laboratory approved to provide high-complexity testing services. Medicare patients must sign an ABN, which is downloadable from the Machaon Diagnostics website. All non-Medicare patients are considered OUT-OF-NETWORK and will be billed for services not covered by their insurance provider. Patient insurance billing services are provided in accordance with the Machaon Insurance Billing Policy. HMO or medical group covered patients may need a prior authorization if they seek full reimbursement. For more information please visit ***MachaonDiagnostics.com*** or call (510) 839-5600.