

Machaon Diagnostics

vWD-Complete™ Genetic Panel

STAT Turnaround Time: 48 hours, M-F / Routine Turnaround Time: 1 week

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1-800-566-3462

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|---|--------------|--|--|--|--|
| PATIENT INFORMATION (complete or attach) | | | SUBMITTING FACILITY | | |
| Patient's Name: (Last, First, M.I.) | | Gender: (circle one) M / F | Facility Phone Number: _____ Fax Number for Results: _____ | | |
| Specimen Date: (MM/DD/YY) Time: AM / PM | | Date of Birth: (MM/DD/YY) | | | |
| Medical Record / ID#: | | Patient's Social Security #: | | | |
| ORDERING PHYSICIAN INFORMATION | | | BILLING INFORMATION | | |
| Physician's Name: (Last, First, M.I.) | | Physician's NPI: | Bill to: <input type="checkbox"/> Facility / Inpatient of Outpatient | | |
| Contact Phone Number: | | Fax Number for Results: | Bill to: <input type="checkbox"/> Insurance / Outpatient | | Currently, there is no payable outpatient benefit from Medicare or Medicaid for this test. |
| Physician's direct phone number to call results: (highly encouraged) | | | <input type="checkbox"/> STAT Samples shipped for weekend arrival must be ordered STAT. Mark FedEx Airbill for 'SATURDAY Delivery.' | | |
| CLINICAL INFORMATION (if available) | | | TEST SELECTION | | |
| Platelet defect present? Yes / No | | Has this patient had a bone marrow transplant? Yes / No / unknown | <input type="checkbox"/> vWD-Complete™ von Willebrand Disease Genetic Panel | | Methodology: Rapid Next Generation sequencing of 2 genes |
| Note: Please attach most recent platelet aggregation report. PLT Count: _____ (K/μL) PFA-100 Results: Normal / Abnormal Hemoglobin: _____ (mg/dL) vWF Profile Results: Ristocetin high-dose / Ristocetin low-dose Fibrinogen: _____ (mg/dL) Normal / Abnormal | | Circle abnormal platelet agonists: Ristocetin high-dose Ristocetin low-dose | | | |
| Ethnicity: (circle one) European, African, Latino, East Asian, South Asian or other: _____ | | | <input type="checkbox"/> Functional Confirmation with vWF Profile with Multimer | | Please separately ship 2 x 1mL aliquots of frozen citrated plasma to our Oakland laboratory. |
| Specimen Collection, Processing and Shipping / call for draw kits (free shipping included) | | | | | |
| 1. Draw 1 lavender top tube (EDTA) and store and ship at room temperature. | | | 6. Place all forms into document sleeve of the biohazard bag. | | |
| 2. Mix tube by inversion, gently to ensure proper mixing. | | | 7. Ensure that no patient-specific information is visible. | | |
| 3. Label tube with patient first and last name, draw date and DOB. | | | 8. Place biohazard bag into the provided FedEx Clinical Pak. | | |
| 4. Enclose tube in Styrofoam box and seal in biohazard bag. | | | 9. Complete the provided FedEx Airbill and affix Airbill pouch to Pak. | | |
| 5. Complete this form and attach insurance billing information. | | | 10. Call FedEx 800-238-5355 for a pick-up. | | |
| Patient Declination: <input type="checkbox"/> No; I do not authorize Machaon Diagnostics to use your deidentified laboratory data and sample for research to learn more about rare bleeding and clotting disorders and facilitate the education of our physician clients. | | | | | |
| OUTPATIENT ONLY: INSURANCE BILLING INFORMATION (complete or attach) | | | | | |
| Insurance Company: (Medicare patients must sign ABN on reverse) | | | 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): | | | OUTPATIENT ONLY: PATIENT SIGNATURE | | |
| (Please complete medical necessity form.) | | | 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. This test is currently not covered or reimbursed by Medicare or Medicaid. This panel is \$1,978 and if ordered STAT, adds \$700; shipping charges may apply. I agree to assume responsibility for payment of all charges not covered by my healthcare insurer. | | |
| ICD-10 Code: | ICD-10 Code: | ICD-10 Code: | 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 California-licensed, CLIA-accredited, CAP-accredited, clinical laboratory approved to provide high-complexity testing services. This test is not covered or reimbursed by Medicare or Medicaid. All patients are considered OUT-OF-NETWORK and will be billed for services not covered by their insurance provider. Medicare patients must sign an ABN, either located on the reverse side of this form or downloaded from the Machaon Diagnostics website. 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 www.MachaonDiagnostics.com or call (510) 839-5600. | | | | | |