CLINICAL SERVICES
Medical Director: Hussam Al-Kateb, MSc, PhD, FACMGG
CLIA #: 03D2055105

ARIZONA

Mail Specimens to:
University of Arizona Genetics Core for Clinical Services (UAGC - CS)
Keating Bioresearch Building
1657 E. Helen Street Room 111H
Tucson, AZ 85721
Phone: (520)626-5002 Fax: (520)626-7701
http://uagcclinical.arizona.edu/

Solid Tumor Gene Panel Requisition

ORDERING PHYSICIAN INFORMATION

Ordering Physician First Name:	**Last Name:**	**Middle Initial:**	**Title/Specialty:**	
Clinic/Institution:	**NPI:**	**State License #:**	**Medicare/Medicaid PTAN:**	**Federal Tax ID:**
Address Line One:	**Address Line Two:**			
City:	**State:**	**Zip**	**Phone:**	**Fax:**
E-mail Address:	**Requisitioner (if different):**		**Requisitioner Phone:**	

PATIENT INFORMATION

Patient's First Name:	**Last Name:**	**Middle Initial:**	**MRN or Other ID (non-SSN):**
DOB (mm/dd/yyyy) / /	**Age:**	**Gender:**	**Parent/Guardian Full Name (if patient is under 18 years of age):**

Ethnic background

African American ☐	**Asian** ☐	**Caucasian/NW European** ☐	**E Indian** ☐	**Hispanic** ☐
Mediterranean ☐	**Native American** ☐	**Native Hawaiian/ Pacific Islander** ☐	**Other**	

Patient status:

Inpatient ☐	**Outpatient** ☐	**Office Visit** ☐

Address Line One:			**Address Line Two:**		
City:	**State:**	**Zip:**	**Home Phone:**	**Work Phone:**	**Cell Phone:**
Email:			**Notes:**		

CLINICAL INFORMATION

ICD-10 Diagnosis Code (Required):	**Indication:**

Specimen Type

Tumor Type	**Tumor Histology**	**Primary site**	**Metastatic site**
Pre-Therapy:		**Post-Therapy**	

Previous Pathology Case Number (if testing from Archival Specimen)

For samples located outside of BUMC submit: (1) Signed Patient Release for Surgical Material Form & (2) Pathology Report

New Specimen:

Date collected:	**Time:**	**Collected by:**

Sample Type (select one):

Formalin Fixed Tissue ☐	**Fresh Frozen Tissue** ☐	**Bone Marrow Aspirate** ☐	**Bone Core** ☐	**Other**

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PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB: (mm/dd/yyyy) / /

Solid Tumor Gene Panel Requisition – Page 2

HEALTHCARE PROVIDER SIGNATURE TO AUTHORIZE TESTING, STATEMENT OF MEDICAL NECESSITY, AND AUTHORIZATION FROM

(TO BE COMPLETED BY PROVIDER)

I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

I authorize the University Of Arizona Genetic Core for Clinical Services (UAGC - CS) Laboratory to receive Protected Health Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) at the facsimile phone number above. I acknowledge that I am responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.

- To comply with HIPAA regulations, any transmission of PHI (e.g. clinical report) must be sent securely.
- The undersigned Provider authorizes the University Of Arizona Genetic Core (UAGC - CS) to send and receive Protected Health Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) to the facsimile phone number listed on the requisition.
- Provider acknowledges they are solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.
- In the event of an erroneous transmission, Provider must immediately notify the sender and to destroy the results.
- Provider may revoke this authorization or change the facsimile number by giving the UAGC - CS at least 24 hours prior notice either verbally or in writing.

Signature of Provider (REQUIRED):	Printed Name:	Date: / /

CERTIFICATION OF INFORMATION AND APPROVAL TO RETRIEVE BENEFITS INFORMATION (TO BE COMPLETED BY PATIENT)

I authorize the disclosure of insurance benefit coverage and payment information to The University of Arizona Genetics Core (UAGC - CS) Division of Clinical Services. I authorize UAGC - CS to furnish any medical information requested on myself, or my covered dependents. I assign and authorize insurance payments to UAGC - CS. I understand I am responsible for any co-pay, deductibles, or non-authorized services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if UAGC - CS is not a participant with my health plan, and/or my health plan does not fully reimburse medical services due to lack of authorization or medical necessity.

By signing below, I certify that the information about me provided in this form is true and correct to the best of my knowledge.

Signature of Patient or Guardian (REQUIRED):	Printed Name:	Date: / /

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PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB: (mm/dd/yyyy) / /

Solid Tumor Gene Panel Requisition – Page 3

Insurance and Precertification

Precertification for all non-government insurance plans is required for genetic testing and will be managed by UAGC - CS. Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. University of Arizona Genetic Core for Clinical Services (UAGC - CS) can only accept authorized and contracted private insurance, Medicare, or Arizona Medicaid programs. Other out-of-state Medicaid programs cannot be billed. Please contact Gina Delgado, Patient Accounts Manager at (520)626-6323, e-mail: gdelgado@email.arizona.edu, for complete insurance filing information and the managed care/private insurance contract list.

Attach copy of insurance card (if not available, complete the following)

Policy holder's Name: Last First MI	Insurance Co. Name:	Insurance Co. Phone:		
Policy holder's DOB (mm/dd/yyyy):	Relationship to Patient:	Plan Name:	ID #:	Group #:

Self-Pay and Patient Financial Assistance

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact Gina Delgado at (520)626-6323 , e-mail: gdelgado@email.arizona.edu

Authorization to Assign Benefits and Accept Financial Responsibility for Account

I authorize the disclosure of insurance benefit coverage and payment information to University of Arizona Genetic Core for Clinical Services (UAGC - CS). I authorize the University of Arizona Genetic Core for Clinical Services (UAGC - CS) to furnish any medical information requested on myself, or my covered dependents. I assign and authorize insurance payments to the University of Arizona Genetic Core for Clinical Services (UAGC - CS). I understand I am responsible for any co-pay, deductibles, or non-authorized services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if University of Arizona Genetic Core for Clinical Services (UAGC - CS) is not a participant with my health plan, and/or my health plan does not fully reimburse medical services due to lack of authorization or medical necessity.

Signature of Patient or Guardian	Printed Name of Patient or Guardian	Date

Reference Laboratories: Complete the Section Below

Institutional Billing

Institution Name:			Contact Name:	
Email:				
Billing Address Line 1:			Billing Address Line 2:	
City:	State:	Zip:	Phone:	Fax:

PROVIDER'S INSTRUCTIONS FOR COMPLETING FILLABLE PDF AND SENDING COMPLETED REQUISITION

- Use the 'Tab' key to move between the fields.
- Complete ALL fields to avoid any delay in processing the requisition.
- Enter phone and fax numbers beginning with area code. You may use dashes and () characters.
- Enter dates as mm/dd/yyyy. (i.e. 01/05/2001).
- Ordering provider's NPI is required.
- Reason for Testing/Diagnosis and ICD9 codes are required in order for us to obtain pre-authorization.

- Complete the requisition and **mail** with the specimen to the address at the top of this form or **fax** to (520)626-7701
- If the requisition is to be emailed to **<email TBD>**, it must be saved as a JPEG (or other non-editable file format), or as a PDF encrypted with a password.
  - **To save form as a JPEG on a PC:** Complete the form in Adobe Reader, then choose "File" > "Save As > "Save As Type" > JPEG.
  - **To save form as a JPEG on a Mac:** Complete the form in Preview, then choose "File" > "Export"> "JPEG" > "Save".
  - **To encrypt a PDF form on a PC:** Complete the form in Adobe Reader (v7.0 or later), then choose "Secure" > "Encrypt with Password". Select "Require a Password to Open the Document", enter and confirm a password, save and close. Send password and requisition in separate emails.
  - **To encrypt a PDF form on a Mac:** Complete the form in Preview, then choose "File" > "Export". Check "Encrypt", enter and verify a password, save and close. Send password and requisition in separate emails.

UAGC - CS Accession Number:	Date Received (mm/dd/yyyy): / /	Receiving Personnel: