Berries Health & GENETICS

Test information is available on our website:
BerriesHealthInc.com

BHGL USE ONLY

All testing must be ordered by a qualified Healthcare Provider

THIS FORM MUST ACCOMPANY ALL SPECIMENS

Berries Health & Genetics Laboratory
TEST REQUISITION

ORDERING CHECKLIST

☐ Patient and comparator (if provided) specimens

☐ Please, include relevant medical records and family health history (i.e. clinic notes, prior genetic testing, pedigree) (required for Diagnostic)

PERSON COMPLETING FORM	**CONTACT (PHONE OR EMAIL)**	**DATE OF REQUEST** (MM/DD/YYYY)

PATIENT INFORMATION

LAST (FAMILY) NAME	**FIRST NAME**	**MI**	**DATE OF BIRTH** (MM/DD/YYYY)

PATIENT ID	**SPECIMEN COLLECTION DATE** (MM/DD/YYYY) If no collection date is provided, date of receipt will be used.	**BIOLOGICAL SEX** ☐ Male ☐ Female ☐ Other SPECIFY KARYOTYPE

SPECIMEN SOURCE Note: Complex sample types may incur an additional fee.

☐ Whole Blood ☐ Other _____
☐ Saliva
☐ Buccal

REASON FOR TEST

☐ Diagnosis / Affected
☐ Presymptomatic / At Risk
☐ Carrier Testing / Unaffected
☐ Adult Comprehensive PGx
☐ Pediatric Mental Health PGx
☐ Paternity

GEOANCESTRY / ETHNICITY

HAS PATIENT BEEN TESTED PREVIOUSLY AT BERRIES HEALTH?
☐ NO ☐ YES, BH ID# _____

HAS PATIENT'S RELATIVE BEEN TESTED PREVIOUSLY AT BERRIES HEALTH?
☐ NO ☐ YES, Name _____
DOB _____ or, BH ID# _____
Relationship to Patient _____

BLOOD TRANSFUSION
☐ NO
☐ Within Last 30 Days, Date and Type
_____ MM/DD/YYYY
_____ TYPE

BONE MARROW TRANSPLANT
☐ NO
☐ YES, include date
_____ MM/DD/YYYY

ICD-10 CODES
(REQUIRED FOR INSURANCE BILLING) 1 PRIMARY_____ 2 _____ 3_____

PATIENT TEST SELECTION

STANDARD DIAGNOSTIC BHG EXOME

☐ **PATIENTONLY**

☐ **FAMILY DUO**

☐ **TRIO**

☐ **OTHER** Specify _____

Complete a Comparator Test Requisition form for each family member.

Clinical information is REQUIRED for each comparator for accurate interpretation.

☐ Include family/comparator demographics (name, DOB, ID#, and relationship) on the proband report.

HEALTH SCREEN BHG EXOME

☐ **PATIENT ONLY**

Includes carrier status.

TEST PANELS

ICD-10 CODES

ADDITIONAL COMPARATORS Complete for BHG EXOME Family Duo or Trio orders

Please submit a separate completed diagnostic or health screen test requisition to request a full analysis of the comparator data for an additional charge, if desired.

NAME (LAST, FIRST)	DATE OF BIRTH (MM/DD/YYYY)	SAMPLE TYPE	RELATIONSHIP TO PROBAND	AFFECTED?*
				☐ NO ☐ YES
				☐ NO ☐ YES
				☐ NO ☐ YES

*If YES, must include clinical info.

202 Central Way, Kirkland, WA 98033 USA | berrieshealthinc.com | info@berrieshealthinc.com | Phone: (425) 821-6649 | Fax: (425) 952-7188

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PATIENT	
LAST NAME	
FIRST NAME	MI

PROVIDER / LABORATORY CONTACT AND REPORTING

Our preferred method of report transmission is uploading to our secure web portal or e-FAX

Please provide an email address, when possible. If you have additional specific reporting requests, indicate them BELOW.

PROVIDER INFORMATION

INSTITUTION			
ADDRESS	**CITY**	**STATE**	**ZIP**
REQUESTING PHYSICIAN (First, Last, Degree)			
EMAIL ADDRESS			
PHONE NUMBER	**NPI#**		

IF YOU REQUIRE REPORTS TO BE TRANSMITTED e-FAX, SPECIFY HERE.

As the ordering Healthcare Provider, I certify that: (1) I have obtained informed consent from the patient and, where applicable, their family members to perform this test, as documented on a signed consent form that complies with relevant laws and is consistent with the Informed Consent form provided by Berries Health and Genetics Laboratory (available at www.berrieshealthinc.com). I will retain this form on file and make it available to Berries Health and Genetics Laboratory upon request; (2) The patient and their family members (if applicable) have received appropriate counseling and understand the risks, benefits, and limitations of this genetic testing, as well as the implications of the results; and (3) I have secured the consent of the patient and family members (if applicable) for Berries Health and Genetics Laboratory to use and disclose information, test results, and samples as specified in the consent form: (4) WHENORDERING TEST FOR WHICH INSURANCE REIMBURSMENT WILL BE SOUGHT, THE PROVIDER SHOULD PROVIDE ALL ICD-10 CODES FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT. IF THE MEDICAL NECESSITY OF THE ORDERED TEST IS NOT PROVIDED, THE TEST MAY BE CONSIDERED A CASH-PAY SERVICE, WHERE THE PATIENT WILL BE RESPONSIBLE FOR COVERING THE TEST OF THE TEST THEMSELVES. IT IS IMPORTANT TO ALWAYS INSURE THAT THE NECESSARY DOCUMENTATION FOR MEDICAL TESTS ARE PROVIDED TO AVOID ADDITIONAL OUT OF POCKET EXPENSESS.

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PATIENT
LAST NAME

FIRST NAME | MI

COMPLETE THIS FORM FOR PATIENT PAY AND/OR INSURANCE BILLING

PATIENT TESTING WILL PROCEED WHEN ALL BILLING INFORMATION HAS BEEN RECEIVED.

** THIS SECTION MUST BE FILLED OUT COMPLETELY **

RESPONSIBLE PARTY'S NAME *(MUST BE 18 YEARS OR OLDER)*		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
EMAIL			

ACCEPTANCE of financial responsibility for genetic testing

SIGNATURE REQUIRED BELOW TO PROCEED WITH TESTING.

MY SIGNATURE INDICATES I ACCEPT FINANCIAL RESPONSIBILITY FOR ALL FEES ASSOCIATED WITH THIS GENETIC TESTING ORDER. If applicable, I authorize Berries Health and Genetics to release information received including, without limitation, medical information, which includes laboratory test results, such as genetic tests results, to my health plan / insurance carrier and its Authorized Representatives. I further authorize insurance payments directly to Berries Health and Genetics for the services rendered. I understand my Health Plan / Insurance / Medicare / Medicaid carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, medical necessity or otherwise. **I understand I am financially responsible for fees not paid in full by my insurer,** co-payments, and policy deductibles except where my liability is limited by contract or State and Federal law. I agree to help Berries Health and Genetics resolve any insurance claim issues. I understand my out-of-network benefits may apply. Berries Health and Genetics may contact me to resolve any billing-related issues and to request payment.

SIGN HERE: Required to process form

_____ _____ _____
PATIENT / RESPONSIBLE PARTY SIGNATURE **PRINTED NAME OF RESPONSIBLE PARTY** **DATE**

PAYMENT METHODS

☐ **IN- PERSON PAY - Pay in-person at Berries Health and Genetics Laboratory office**
Patient will be charged before specimen is collected.

☐ **CREDIT CARD PAY - Fill out credit card information section to have the test kit shipped to your house**
Card information provided below will be charged when specimen arrives.

☐ **INSURANCE PAY - INSURANCE BILLING - Fill out insurance information section - attach copies of both sides of the insurance card**
Insurance will be billed. Patient is responsible for any co-pays.

CREDIT CARD INFORMATION - IF APPLICABLE

CREDIT CARD NUMBER (VISA, DISCOVER, OR MASTERCARD ONLY)	EXPIRATION DATE	3-DIGIT SECURITY CODE

My signature authorizes Berries Health and Genetics to charge my credit card for services for which I am responsible.

SIGN HERE: Required to process credit cad _____ _____
CREDIT CARD HOLDERS SIGNATURE **DATE**

INSURANCE INFORMATION - IF APPLICABLE

INDICATE THE TYPE OF INSURANCE ☐ **Attach a copy of Insurance Card (both sides)**

☐ **PRIVATE** ☐ **TRICARE** *include signed Tricare waiver* ☐ **MEDICARE** *include signed ABN form* ☐ **WA MEDICAID** *We only accept WA Medicaid*

POLICY HOLDER NAME	DATE OF BIRTH (MM/DD/YYYY)	RELATIONSHIP TO PATIENT

PRIMARY INSURANCE COMPANY NAME (REQUIRED)	PHONE NUMBER

POLICY ID#	GROUP #	AUTHORIZATION # ☐ *Attach copy of authorization, PreventionGenetics must be listed as servicing provider.*

☐ **Attach a copy of Insurance Card (both sides)**

TESTING WILL PROCEED UNLESS:

- Provider or patient are working on a required Pre-Authorization.
- No insurance coverage is available. We will work with you or your patient to determine payment options.

OR PLEASE PROVIDE YOUR PREFERENCES BELOW:

☐ **PROCEED WITH TESTING:** patient accepts financial responsibility for test; regardless of insurance coverage.

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