

### CANCER CYTOGENETICS TEST REQUISITION

**SHIP TO: MEDICAL GENETICS LABORATORIES**

Baylor College of Medicine  
2450 Holcombe, Grand Blvd. - Receiving Dock  
Houston, TX 77021-2024

**!STOP IMPORTANT BILLING INFORMATION!**

Indicate Institution Billing Code here: \_\_\_\_\_, **OR**  
complete and fax billing information form (page 2 of requisition)  
to 713-798-4187. **Samples received without the Institution  
Code or Billing Form cannot be processed.**

**PATIENT DATA**

NAME (Last, First, Middle Initial): \_\_\_\_\_  
DATE OF BIRTH (MM/DD/YY): \_\_\_\_/\_\_\_\_/\_\_\_\_  
Please check one:  MALE  FEMALE  UNKNOWN  
HOSPITAL #: \_\_\_\_\_  
ACCESSION #: \_\_\_\_\_  
KCL #: \_\_\_\_\_  
MEDICAL RECORD #: \_\_\_\_\_

**REPORTING INFORMATION**

PHYSICIAN/INSTITUTION: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_  
PHONE #: (\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_  
Additional Reports to:  
1. NAME: \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_  
2. NAME: \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

### SAMPLE INFORMATION

DATE SAMPLE OBTAINED (MM/DD/YY): \_\_\_\_/\_\_\_\_/\_\_\_\_ TIME SAMPLE OBTAINED: \_\_\_\_\_

**SAMPLE TYPE:**

- BONE MARROW  
 BLOOD (Hem/Onc)

WBC COUNT: \_\_\_\_\_ PERCENT BLASTS: \_\_\_\_\_

BMT DONOR: (Check One)  MALE  FEMALE

### TESTING INFORMATION

*Must be completed thoroughly to avoid delay in sample processing.*

**INDICATION FOR STUDY (MUST check one or more below)**

- Acute Lymphoblastic Leukemia  
 Acute Myeloid Leukemia  
 Chronic Myelogenous Leukemia  
 Chronic Lymphocytic Leukemia  
 Myelodysplastic Syndrome  
 Hairy Cell Leukemia  
 Hodgkin s Lymphoma  
 Non-Hodgkin s Lymphoma, B-cell  
 Non-Hodgkin s Lymphoma, T-cell  
 Plasma Cell Neoplasms (includes Multiple Myeloma)  
 Other: \_\_\_\_\_

**TEST REQUESTED (Check all appropriate boxes)**

8300	<input type="checkbox"/>	Oncology Chromosomes Analysis	8330	<input type="checkbox"/>	MLL [t(11)(q23)] FISH Analysis
			8330	<input type="checkbox"/>	BCR/ABL [t(9;22)] FISH Analysis
8320	<input type="checkbox"/>	Deletion 5q FISH Analysis	8330	<input type="checkbox"/>	TEL/AML1 [t(12;21)] FISH Analysis
8320	<input type="checkbox"/>	Deletion 7q FISH Analysis	8330	<input type="checkbox"/>	MYC translocation FISH Analysis
8320	<input type="checkbox"/>	Deletion 20q12 FISH Analysis	8330	<input type="checkbox"/>	IGH/BCL2 [t(14;18)] FISH Analysis
			8330	<input type="checkbox"/>	IGH/CCND1 [t(14;11)] FISH Analysis
8330	<input type="checkbox"/>	AML1/ETO [t(8;21)] FISH Analysis			
8330	<input type="checkbox"/>	FIPIL1-PDGFR4(4q12)FISH Analysis	8340	<input type="checkbox"/>	CLL FISH Panel (6q, 13q14, 13q34, cen12, 17p13, 11q23)
8330	<input type="checkbox"/>	PML/RARA [t(15;17)] FISH Analysis	8340	<input type="checkbox"/>	Multiple Probes Analysis
8330	<input type="checkbox"/>	CBFB [inv(16)] FISH Analysis			

Previous Cytogenetic Results (if applicable): \_\_\_\_\_  
Performed Where: \_\_\_\_\_

**BILLING INFORMATION FORM**

**STOP! ONE OF THE THREE FOLLOWING BILLING OPTIONS MUST BE INDICATED BELOW.**

The Self-Pay option must include payment with sample. We require and provide insurance pre-verification service. Please fax the *Patient Insurance Verification Form* (available at www.bcmgeneticlabs.org) to 713-798-4187. If the Billing Information section is incomplete, the referring physician, hospital, or laboratory will automatically be billed, or sample processing suspended. Please forward billing questions to: medgenbilling@bcm.edu

**PATIENT INFORMATION:**

Name (Last, First, Middle Initial): \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone #: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

**PAYMENT OPTIONS:**

1.  **Institution or referring MD Code (as assigned by BCM):** \_\_\_\_\_  
(or) Institution Name: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Financial Contact: \_\_\_\_\_  
E-mail (required): \_\_\_\_\_  
Phone #: (\_\_\_\_) \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_

2.  **Self-Pay: Check, Money Order, or Credit Card payment must accompany sample.**  
Credit Card (Please check one):  AMEX  Discover  MC  VISA  
Valid Card #: \_\_\_\_\_ Exp date (mm/yy): \_\_\_\_/\_\_\_\_ **CVC Code:** \_\_\_\_\_  
Cardholder printed name: \_\_\_\_\_  
Cardholder signature: \_\_\_\_\_

3.  **Insurance:** Please refer to the Financial Policy at <http://www.bcm.edu/geneticlabs/billing.html> for complete insurance filing information and managed care contract list. Insurance is filed to our contracted carriers as a courtesy. Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. HMO policies must have required authorizations. We do not file out-of-state Medicaid. Prenatal CMA requires a prepayment amount. Contact medgenbilling@bcm.edu with questions.

ICD9 Diagnosis Code(s) must be provided or insurance cannot be filed: **ICD-9 CODE:** \_\_\_\_\_  
 PPO, Commercial Insurance-provide Patient Insurance Verification form (PIVF) and front/back copy of card  
 HMO-provide PIVF, authorization, front/back copy of insurance card  
 Texas Medicaid/Texas Medicaid HMO-provide PIVF, authorization, front/back copy of Medicaid card

**Insured Policyholder's Information:**

Name: \_\_\_\_\_ Date Of Birth (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Insured SS or ID #:** \_\_\_\_\_ Gender (Please check one):  M  F  
Authorization: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Insurance Name: \_\_\_\_\_  
Employer: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
Insurance City, State, Zip: \_\_\_\_\_  
Insurance Phone #: (\_\_\_\_) \_\_\_\_\_

I authorize BCM Medical Genetics Laboratories to furnish any medical information requested on myself, or my covered dependents. In consideration of services rendered, I transfer and assign any benefits of insurance to BCM Medical Genetics Laboratories. I understand I am responsible for any co-pay, deductible, or non-covered service amounts. I understand I am fully responsible for payment of my account if the BCM Medical Genetics Laboratories is not a participant with my health plan, and my health plan does not fully reimburse my medical services due to lack of authorization or medical necessity.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_