BAYLOR MIRACA GENETICS LABORATORIES

PHONE: 800-411-GENE | FAX: 713-798-2787 | www.bmgl.com

SHIP TO: Baylor Miraca Genetics Laboratories
2450 Holcombe, Grand Blvd. -Receiving Dock
Houston, TX 77021-2024
Phone: 713-798-6555

CANCER MOLECULAR ANALYSIS REQUISITION - GERMLINE TESTS

PATIENT INFORMATION

NAME: _____ (LAST NAME) _____ (FIRST NAME) ___ (MI)

DATE OF BIRTH: ___ / ___ / ___ (MM / DD / YY)

GENDER (Please select one): ☐ FEMALE ☐ MALE

MEDICAL RECORD #: _____

ACCESSION #: _____

HOSPITAL #: _____

ETHNIC BACKGROUND (Select all that apply):

- ☐ AFRICAN AMERICAN
- ☐ ASIAN
- ☐ ASHKENAZIC JEWISH
- ☐ EUROPEAN CAUCASIAN
- ☐ HISPANIC
- ☐ NATIVE AMERICAN INDIAN
- ☐ OTHER JEWISH
- ☐ OTHER (Please specify): _____

REPORTING INFORMATION

PHYSICIAN: _____

INSTITUTION: _____

PHONE: _____ FAX: _____

EMAIL (INTERNATIONAL CLIENT REQUIREMENT): _____

ADDITIONAL PROFESSIONAL REPORT RECIPIENTS

NAME: _____

PHONE: _____ FAX: _____

NAME: _____

PHONE: _____ FAX: _____

SAMPLE INFORMATION

DATE OF COLLECTION: ___ / ___ / ___ (MM / DD / YY) TIME OF COLLECTION: _____

SAMPLE TYPE: ☐ Blood in EDTA (purple-top) ☐ Other: _____

Did the Patient have a bone marrow transplant? ☐ YES ☐ NO

If YES, please contact lab to discuss sample options

PLEASE CONTACT THE LABORATORY TO DISCUSS ALTERNATE SAMPLE TYPES: 1-800-411-GENE

PATIENT/FAMILY HISTORY

☐ PERSONAL HISTORY:

TYPE OF CANCER: _____

CANCER LOCATION: _____

AGE AT DIAGNOSIS: _____

☐ FAMILY HISTORY (include relationship to family member, cancer type, age at diagnosis):

☐ FAMILIAL MUTATION/VARIANT ANALYSIS:

Complete all fields below and attach the proband's report.

GENE NAME: _____

MUTATION/UNCLASSIFIED VARIANT: _____

THIS INDIVIDUAL IS CURRENTLY: ☐ SYMPTOMATIC ☐ ASYMPTOMATIC

NAME OF PROBAND: _____

RELATIONSHIP TO PROBAND: _____

BMGL LAB#: _____

IF PROBAND TESTING WAS PERFORMED AT ANOTHER LAB, CALL TO DISCUSS PRIOR TO SENDING SAMPLE. A POSITIVE CONTROL MAY BE REQUIRED IN SOME CASES.

REQUIRED: NEW YORK STATE PHYSICIAN SIGNATURE OF CONSENT

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. I have answered this person's questions. I have obtained informed consent from the patient or their legal guardian for this testing.

Physician's Printed Name:_____ Signature:_____ Date (MM/DD/YY):_____

HEREDITARY CANCER PANELS

Full gene sequencing by Next-Generation Sequencing and deletion/duplication analysis.

☐	20004	Comprehensive Hereditary Cancer	61 GENES	Please see website for full list of genes
☐	22304	Brain/CNS/PNS Cancer	17 GENES	*ALK, APC, ATM, MEN1, MLH1, MRE11A, MSH2, MSH6, NBN, NF2, PALB2, PHOX2B, PMS2, PTCH1, SUFU, TP53, VHL*
☐	22404	Breast/Ovarian/Endometrial Cancer	23 GENES	*ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, MLH1, MRE11A, MSH2, MSH6, MUTYH, NBN, PALB2, PMS1, PMS2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53*
☐	23000	Breast Cancer, High Risk	7 GENES	*BRCA1, BRCA2, CDH1, PALB2, PTEN, STK11, TP53*

PANEL OPTIONS CONTINUE ON PAGE 2

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NAME: _____ (LAST NAME) _____ (FIRST NAME) ____ (MI) DATE OF BIRTH: ____ / ____ / ____ (MM / DD / YY) GENDER (Please select one): ☐ FEMALE ☐ MALE ☐ UNKNOWN

HEREDITARY CANCER PANELS (cont.)

Full gene sequencing by Next-Generation Sequencing and deletion/duplication analysis.

☐	22604	Endocrine Cancer	15 GENES	*CDC73, MAX, MEN1, PRKAR1A, PTEN, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, TP53, TSHR, VHL*
☐	22804	Gastrointestinal (GI) Cancer	22 GENES	*APC, ATM, BMPR1A, BRCA1, BRCA2, CDH1, CDK4, CDKN2A, CHEK2, ENG, EPCAM, MLH1, MSH2, MSH6, MUTYH, PALB2, PMS1, PMS2, PTEN, SMAD4, STK11, TP53*
☐	23204	Colorectal Cancer, High Risk	12 GENES	*APC, BMPR1A, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, SMAD4, STK11, TP53*
☐	22704	Leukemia/Lymphoma	13 GENES	*ATM, BRCA2, BRIP1, CBL, CEBPA, GATA2, PALB2, PAX5, PRF1, PTPN11, RUNX1, SBDS, TP53*
☐	22904	Melanoma	4 GENES	*BRCA2, CDKN2A, CDK4, TP53*
☐	23304	Pancreatic Cancer	16 GENES	*APC, ATM, BMPR1A, BRCA1, BRCA2, CDK4, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, SMAD4, STK11, TP53*
☐	23104	Paraganglioma/Pheochromocytoma	9 GENES	*MAX, RET, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL*
☐	23404	Prostate Cancer	5 GENES	*BRCA1, BRCA2, CHEK2, NBN, TP53*
☐	22504	Renal Cancer	12 GENES	*CDKN1C, FH, FLCN, GPC3, MET, PTEN, SDHA, SDHB, SDHC, SDHD, VHL, WT1*

NOTE: For single gene sequencing and deletion/duplication analysis for select genes from the panels, please include the gene name and test code below:

GENE NAME: _____ TEST CODE: _____ GENE NAME: _____ TEST CODE: _____

CANCER MOLECULAR ANALYSIS AVAILABLE

For Familial Mutation/Variant Analysis, complete indication information on page 1.

SAMPLE TYPE: Blood in EDTA (purple-top) tube(s)

APC-Associated Polyposis Conditions		
☐	6720	*APC* Comprehensive (Seq & Del/Dup Analysis)
☐	6087	*APC* Sequence Analysis
☐	6721	*APC* Deletion/Duplication Analysis (by MLPA)
Familial Thrombocytopenia with Propensity to AML		
☐	6520	*RUNX1* Sequence Analysis
Hereditary Breast/Ovarian Cancer		
☐	22350	*BRCA1 & BRCA2* Comprehensive Sequence & CNV Analysis by NGS
Hereditary Leiomyomatosis and Renal Cell Cancer (FH-Related Disorders)		
☐	3740	*FH* Sequence Analysis
Hereditary Non-Polyposis Colon Cancer (HNPCC) - Blood Analysis		
☐	6726	HNPCC PLUS: *MLH1, MSH2, MSH6, & PMS2* Seq & Del/Dup Analysis & *EPCAM* Del/Dup Analysis
☐	6725	*MLH1, MSH2, & MSH6* Comprehensive (Seq & Del/Dup Analysis)
☐	6705	*MLH1* Comprehensive (Seq & Del/Dup Analysis)
☐	6095	*MLH1* Sequence Analysis
☐	6706	*MLH1* Deletion/Duplication Analysis (by MLPA)
☐	6710 & 6888	*MSH2* Comprehensive (Seq & Del/Dup Analysis)AND *EPCAM* Deletion/Duplication Analysis (by MLPA)
☐	6096	*MSH2* Sequence Analysis
☐	6711 & 6888	*MSH2* Deletion/Duplication Analysis AND *EPCAM* Deletion/ Duplication Analysis (by MLPA)
☐	6715	*MSH6* Comprehensive (Seq & Del/Dup Analysis)
☐	6097	*MSH6* Sequence Analysis
☐	6716	*MSH6* Deletion/Duplication Analysis (by MLPA)
☐	6890	*PMS2* Comprehensive (Seq & Del/Dup Analysis)
☐	6640	*PMS2* Sequence Analysis
☐	6795	*PMS2* Deletion/Duplication Analysis (by MLPA)
☐	6888	*EPCAM* Deletion/Duplication Analysis (by MLPA)

Li-Fraumeni Syndrome (LFS)		
☐	6821	*TP53* Comprehensive (Seq & Del/Dup Analysis)
☐	6118	*TP53* Sequence Analysis
☐	6820	*TP53* Deletion/Duplication Analysis (by MLPA)
Multiple Endocrine Neoplasia, Type 1		
☐	3665	*MEN1* Sequence Analysis
Multiple Endocrine Neoplasia, Type 2 (RET-Related Disorders)		
☐	3660	*RET* Sequence Analysis
MUTYH (MYH) - Associated Polyposis		
☐	6120	*MUTYH (MYH)* Sequence Analysis
☐	6104	*MUTYH (MYH)* Mutation PANEL (2 Mutations)
PHEO and PGL Syndromes		
☐	3600	*SDHB*, *SDHC*, & *SDHD* Sequence PANEL
☐	3185	*SDHB* Sequence Analysis
☐	3190	*SDHC* Sequence Analysis
☐	3195	*SDHD* Sequence Analysis
PTEN-Related Disorders		
☐	6790	*PTEN* Comprehensive (Seq & Del/Dup Analysis)
☐	6505	*PTEN* Sequence Analysis
☐	6785	*PTEN* Deletion/Duplication Analysis (by MLPA)
Rothmund-Thomson Syndrome (RECQL4 -Related Disorders)		
☐	6121	*RECQL4* Sequence Analysis
Von Hippel-Lindau Syndrome		
☐	6770	*VHL* Comprehensive (Seq & Del/Dup Analysis)
☐	6765	*VHL* Sequence Analysis
☐	6775	*VHL* Deletion/Duplication Analysis (by MLPA)

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BILLING INFORMATION

IMPORTANT NOTICE: ONE OF THE THREE FOLLOWING BILLING OPTIONS MUST BE INDICATED BELOW.
PLEASE FORWARD ALL BILLING QUESTIONS TO: MEDGENBILLING@BCM.EDU

PATIENT INFORMATION

PATIENT NAME (LAST,FIRST, MI): _____ PATIENT DATE OF BIRTH (MM/DD/YY): _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ EMAIL: _____

☐ PAYMENT OPTION - INSTITUTION

INSTITUTION NAME: _____ INSTITUTION CODE: _____

CONTACT NAME: _____ EMAIL (REQUIRED): _____

BILLING ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ FAX: _____

☐ PAYMENT OPTION - SELF-PAY (PAYMENT MUST ACCOMPANY SAMPLE)

☐ CREDIT CARD (PLEASE SELECT ONE): ◯ AMEX ◯ DISCOVER ◯ MC ◯ VISA

VALID CARD #: _____ EXPIRATION DATE (MM/YY): _____ CVC CODE: _____

BILLING ADDRESS: _____ CITY, STATE, ZIP: _____

CARDHOLDER PRINTED NAME: _____ CARDHOLDER SIGNATURE: _____

☐ CHECK/MONEY ORDER: CHECK/MONEY ORDER #: _____ AMOUNT ENCLOSED: _____

☐ PAYMENT OPTION - INSURANCE

☐ INSURANCE OPTION 1 (WITH PRE-AUTHORIZATION) ☐ INSURANCE OPTION 2 (WITHOUT PRE-AUTHORIZATION)

PROVIDE A LEGIBLE PHOTOCOPY OF THE FRONT & BACK OF THE INSURANCE CARD OR HMO/MEDICAID HMO AUTHORIZATION/REFERRAL.

Please refer to the Financial Policy at www.bmgl.com for complete insurance filing information and managed care contract list. Insurance is filed to our contracted carriers as a client service 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 approved authorizations. Baylor Miraca Genetics Laboratories cannot bill out-of-state welfare programs. We accept authorized Texas Medicaid HMO covered charges for genetic testing. Please contact our office prior to submitting a Texas Medicaid sample. Contact medgenbilling@bcm.edu with questions.

ORDERING PROVIDER: _____

◯ ICD9 Diagnosis Code(s) - must be provided or insurance cannot be filed: _____

◯ PPO, POS, Commercial Insurance - Provide complete member information with legible front & back photocopy of insurance card.

◯ HMO - Provide approved authorization #: _____ and attach legible front & back photocopy of insurance card.

Texas Medicaid HMO - Provide approved authorization #: _____ and contact Billing at 713-798-6555.

INSURED MEMBER'S INFORMATION

MEMBER NAME (Last, First, MI): _____ MEMBER DATE OF BIRTH (MM/DD/YY): _____ GENDER: ◯ FEMALE ◯ MALE

MEMBER POLICY #: _____ MEMBER SS #: _____ MEMBER GROUP #: _____

INSURANCE CO. NAME: _____ PHONE: _____

INSURANCE CO. ADDRESS: _____ CITY, STATE, ZIP: _____

I AUTHORIZE BAYLOR MIRACA 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 BAYLOR MIRACA GENETICS LABORATORIES. 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 THE BAYLOR MIRACA 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. I HAVE READ AND FULLY UNDERSTAND THE INSURANCE BILLING INFORMATION AND OPTION EXPLANATION. I ACCEPT ALL FINANCIAL RESPONSIBILITY BASED ON MY INSURANCE OPTION CHOICE.

PRINTED NAME: _____ SIGNATURE: _____ DATE (MM/YY): _____