BCM-MEDICAL GENETICS LABORATORIES

PHONE: 800-411-GENE | FAX: 713-798-2787 | www.bcmgeneticlabs.org

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

CUSTOM REQUISITION

PATIENT INFORMATION

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

DATE OF BIRTH: ___ / ___ / ___ (MM / DD / YY) GENDER (Please select one): ☐ FEMALE ☐ MALE ☐ UNKNOWN

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

HOSPITAL#: _____ ACCESSION#: _____

SAMPLE TYPE (Please select one):

- ☐ BLOOD
- ☐ CORD BLOOD
- ☐ SKELETAL MUSCLE
- ☐ MUSCLE
- ☐ DNA (Specify Source): _____
- ☐ OTHER (Specify): _____

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: _____

ADDRESS: _____

CITY,STATE, ZIP: _____

PHONE: _____ *FAX: _____

ADDITIONAL PROFESSIONAL REPORT RECIPIENTS

NAME: _____

PHONE: _____ *FAX: _____

NAME: _____

PHONE: _____ *FAX: _____

*BCM-MEDICAL GENETIC LABORATORIES HAS A FAX ONLY POLICY FOR REPORTING

INDICATION FOR STUDY

☐ SYMPTOMATIC (Summarize below.):

☐ ASYMPTOMATIC/POSITIVE FAMILY HISTORY: (ATTACH FAMILY HISTORY)

RELATIONSHIP TO PROBAND: _____

*If family mutation is known, complete the KFM TESTING section.

☐ ASYMPTOMATIC/POPULATION SCREENING

OTHER (Specify clinical findings below.):

☐ *KNOWN FAMILIAL MUTATION (KFM) TESTING:

COMPLETE ALL FIELDS BELOW AND ATTACH THE PROBAND'S REPORT.

GENE NAME: _____

MUTATION: _____

THIS INDIVIDUAL IS CURRENTLY: ☐ SYMPTOMATIC ☐ ASYMPTOMATIC

NAME OF PROBAND: _____

RELATIONSHIP TO PROBAND: _____

BCM LAB#: _____

IF PROBAND TESTING WAS PERFORMED AT ANOTHER LAB, CALL TO DISCUSS CASE FIRST.

TESTS

PHYSICIAN SIGNATURE OF CONSENT REQUIRED BELOW

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):_____

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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 1 - INSTITUTION

INSTITUTION NAME: _____ INSTITUTION CODE: _____

CONTACT NAME: _____ EMAIL (REQUIRED): _____

BILLING ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ FAX: _____

☐ PAYMENT OPTION 2 - 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 3 - INSURANCE

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.bcmgeneticlabs.org 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. BCM-Medical Genetic 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.

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 713-798-5849.

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 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, DEDUCTIBLES, OR NON-AUTHORIZED SERVICES AND REMAINING BALANCES AFTER INSURANCE REIMBURSEMENT. 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/YY): _____