CYSTIC FIBROSIS (CF) REQUISITION

MLabs
Expertise Delivered Personally

Michigan Medicine – University of Michigan
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Client
REFR

Ward
REFR

Patient Reg or MRN:

Patient Name: Last First MI

Birthdate: Gender: ○M ○F

Ordering Doctor: Last First NPI#

Patient Address City State ZIP Home Phone #

Policy Holders Name | Primary Insurance (Card Name) | Primary Policy/Contract # | Primary Group # | Policy Holders DOB

Policy Holders Name | Secondary Insurance (Card Name) | Secondary Policy/Contract # | Secondary Group # | Policy Holders DOB

Bill To: ☐ Client/Referring Institution ☐ Patient/Insurance

☐ Medicare = ☐ In Patient on DOS ☐ Out Patient on DOS ☐ Non Patient on DOS

If patient or insurance information is not included or attached to this form, your facility will be billed. For Medicare patients classified as a hospital inpatient or outpatient on the date of service, charges must be billed to the referring client.

Prior Authorization: Most insurance carriers require prior authorization for payment. To obtain BCN prior authorization call Joint Venture Hospital Laboratories (JVHL) at 800-445-4979; for HAP refer to CareAffiliate via www.hap.org; for all others, contact the plan directly.

☐ Prior authorization obtained Authorization number: _____

Informed Consent: A consent form is required by Michigan law for presymptomatic or predictive genetic tests. It is the responsibility of the physician (or designee) to obtain this consent. If desired, a UMHS Request and Consent for Genetic Testing form can be obtained by contacting MLabs at 800-862-7284 or online at http://mlabs.umich.edu/files/pdfs/PCI-MMGL_InformedConsent.pdf.

☐ Informed consent obtained (please attach a copy).

ICD-10 CODES

ICD-10 Codes are required for billing. When ordering tests for which reimbursement will be sought, order only tests that are medically necessary for the diagnosis and treatment of the patient.

REFERRING PHYSICIAN TO BE CONTACTED WITH RESULTS AND/OR QUESTIONS

Referring Physician Referring Institution Phone Fax

Address City State ZIP Country

This request to order tests from MLabs certifies to MLabs that (1) the ordering physician has obtained written informed consent from the patient as required by applicable state or federal laws for each test ordered and (2) the ordering physician has authorization from the patient permitting MLabs to report results for each test ordered to the ordering physician.

PATIENT HISTORY/DIAGNOSIS – REQUIRED INFORMATION

Collection Date:_____ Time: _____ (○am ○pm) Footnote: Case/Accn #_____

Differential diagnosis / Clinical question(s): ☐ Pregnancy ☐ Pre-conception ☐ Other: _____

Ethnic Background of Origin: ☐ Caucasian - European ☐ Caucasian - Jewish (Ashkenazi) ☐ Hispanic ☐ Asian ☐ Black ☐ Other: _____

☐ Mixed Ethnic Origin, please specify: _____

Is there a family history of Cystic Fibrosis?

☐ Yes ☐ No ☐ Unknown If yes, please provide details: _____

If specimen is from baby's Father, please include:

Baby's Mother's Name: _____ Mother's Registration Number: _____

Mother's CF Screening Result: ☐ Positive ☐ Negative If Positive, What Mutation: _____

All tests include pathologist interpretation at a separate additional charge.

☐ Cystic Fibrosis Carrier Screening (INPLX)(MolDx): mutation panel for general population, pre-conception, or prenatal screening. — CPT 81220

☐ Cystic Fibrosis Diagnostic Mutation Detection (CFDXL)(MMGL): mutation panel for newborns and children to confirm diagnosis of CF; use if suspect cystic fibrosis due to clinical history and/or sweat chloride results. — CPT 81220

☐ CFTR Gene Sequencing (CFTRS)(MMGL): detects presence of CFTR mutations for use in patients with CFTR-related disorders and for confirmation of diagnosis in patients who had no mutations detected by screening but have a clinical presentation consistent with CF. — CPT 81223

☐ CFTR Deletion/Duplication (CFTD)(MMGL): detects presence of CFTR deletions and duplications for use in patients with only one or no CFTR mutations detected by sequence analysis but with a clinical presentation consistent with CFTR-related disorders or on relatives of a patient with a known CFTR deletion/duplication mutation. — CPT 81222

☐ CFTR Panel: Gene Sequencing with reflex to Del/Dup (CFT1S)(MMGL): includes CFTR full gene sequencing, and if only one or no CFTR mutation is detected CFTR gene deletion and duplication analysis is performed. — CPT 81223 Gene Sequencing, 81222 Del/Dup (if applicable)

☐ CFTR Targeted Sequencing, Familial (CFTRF)(MMGL): diagnostic or predictive testing when 1 or more mutations have been identified in a family member. — CPT 81221

Specimen Type for all assays: Peripheral Blood, 5-10 mL Lavender/EDTA tube

Copy Distribution: White – MLabs Mol Dx Yellow – MLabs SP Pink – Client

Revised: 4-11-17 Z REFR