



Michigan Medicine Laboratories (MLabs)

N-LNC Specimen Processing
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Ann Arbor, MI 48109-2800

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MMGL MOLECULAR GENETICS REQUISITION

Client information fields: Patient Reg or MRN, Patient Name (Last, First, MI), Birthdate, Gender (OM, OF), Ordering Doctor (Last, First, NPI#), Ward.

Insurance information fields: Patient Address, City, State, ZIP, Home Phone #, Policy Holders Name, Primary Insurance (Card Name), Primary Policy/Contract #, Primary Group #, Policy Holders DOB, 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. Includes text: If patient or insurance information is not included or attached to this form, your facility will be billed.

Prior Authorization: Most insurance carriers require prior authorization for payment. To obtain Blue Care Network (BCN) prior authorization call Joint Venture Hospital Laboratories (JVHL) at 800-445-4979. For all other carriers contact the plan directly. Includes field for 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. Includes checkbox for 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. Fields for Referring Physician, Referring Institution, Address, City, State, ZIP, Phone, Fax, 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. Fields for Diagnosis, Collection Date, Time, Footnote: Case/Accn #.

All tests include pathologist interpretation at a separate additional charge.

TEST PANELS: MICROARRAY, AUTISM / INTELLECTUAL DISABILITY, MECP2 (Rett Syndrome), PTEN Hamartoma Tumor Syndrome (PHTS), SHANK2/3, SLC9A6, TCF4, UBE3A, HEARING LOSS, NOONAN SYNDROME, OTHER (ATP7B, BTD, CHD7, DiGeorge Panel, GAA, MSH2, NF1, NOGGIN, Ornithine Transcarbamylase Deficiency, PAI1, SERPINE1, SETBP1, SLC7A7, SMN1&2 Deletion, TP53).

Specimen Type for all assays: Peripheral Blood, 5-10 mL Lavender/EDTA tube For technical questions, call lab (734) 615-2429