GOPATH®
LABORATORIES
Global Pathology Services

HEREDITARY REQUISITION

Tel: 855.467.2849 | Fax: 224.588.9941 | E-mail: info@gopathlabs.com

PATIENT INFORMATION (Please print)

Name (Last, First) ______________________

Address ______________________

City, State, Zip ______________________

Phone # ______________________

☐ Male ☐ Female Date of Birth *(MM/DD/YYYY)* ______________________

Race/Ethnicity ☐ White/Caucasian ☐ Black/African American ☐ East Asian ☐ Hispanic ☐ Other ____________

Diagnosis ______________________

ORDERING PHYSICIAN / LAB INFORMATION (Please Print)

Facility Name ______________________

Ordering Physician ______________________

NPI # ______________________

Address ______________________

City, State, Zip ______________________

Email ______________________

Phone # ______________ Fax # ______________

BILLING INFORMATION (Please provide copy of insurance card)

Primary Insurance:
(Please attach copy) ______________________

Bill: ☐ Insurance ☐ Medicare ☐ Medicaid ☐ Hospital ☐ Client ☐ Self Pay

Secondary Insurance:
(Please attach copy) ______________________

Place of Service:
☐ 21 - Inpatient Hospital ☐ 22 - Outpatient Hospital
☐ 11 - Office ☐ 24 - Ambulatory Surgery Ctr
☐ Client Bill ☐ Outpatient

CODING INFORMATION

Diagnosis Code/ICD-10 Code (Required): ______________

The physician is required to document all applicable ICD codes or descriptions for all tests ordered supporting medical necessity which shall be used in patient plan of care. Example: ICD-10: Z80.0 (Family Hx of GI cancer)

COMMON ICD-10 CODES

Breast/Ovarian: C50.912, C50.911, D05.00, D05.10, D05.90, C50.919, C50.929, C56.9, D07.30, Z15.01, Z15.02, Z15.03, Z80.3, Z80.41, Z80.42, Z84.81, Z85.3, Z85.43
Colorectal: C20, C21.0, D01.0, D01.1, D01.2, D01.3, D01.40, D01.7, D01.9, K63.5, Z80.0, Z83.71, Z83.70, Z83.79, Z86.01, Z85.00, C18.9, C19
Diabetes: E10, E11, E11.9, E16.2, E23.2, P70.2
Melanoma: C25.9, C43.9, D01.7, D01.9, D03.9, D04.9, Z80.0, Z84.81, Z85.820
Prostate: C61, D07.5, R97.2, Z15.03, Z80.42, Z84.81, Z85.46

OTHER REQUIRED INFORMATION

Genetic Counselor Requested? ☐ Yes ☐ No

HEREDITARY TESTING

☐ **BRCA*NOW*®** (BRCA1/2 & BRCA 1/2 dup/del analysis)
  ☐ Reflex to **BRCA*NOW*®** Extended

☐ **BRCA*NOW*® Extended - Comprehensive Risk Panel**
(APC, ATM, BARD1, BMPR1A, BRCA1/2, BRCA1/2 dup/del, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, MLH1, MSH2, MSH6, MRE11A, MUTYH, NBN, NF1, NF2, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, SMAD4, STK11, TP53, VHL)

INDIVIDUAL TESTING
☐ BRCA1 TARGET ANALYSIS ☐ ASHKENAZI JEWISH
☐ BRCA2 TARGET ANALYSIS ☐ BRCA1/2 del/dup ANALYSIS

☐ **DIABETES*NOW*™ - Comprehensive Diabetes Panel**
(*HNF4A, GCK, HNF1A, HNF1B, NEUROD1, CEL, INS, PDX1, ABCC8, KCNJ11, APPL1, WFS1, RFX6, PCBD1, BLK, PAX4, KLF11,* SNP-BASED T1D and T2D GRS)

BMI: ____________ Age of Diabetes Onset: ____________

☐ **GENETICS*NOW*® Comprehensive 88 Gene Panel**
(Please visit our website for complete gene list)

☐ **LYNCH*NOW*™ (MLH1, MSH2, MSH6, PMS2, EPCAM only)**
  ☐ Reflex to **LYNCH*NOW*™** Extended

☐ **LYNCH*NOW*™ Extended - Comprehensive Risk Panel**
(APC, AXIN2, BLM, BMPR1A, BRCA1/2, BUB1B, CDH1, CDK4, CDKN2A, CHEK2, EPCAM, EXO1, FLCN, GREM1, MLH1, MLH3, MSH2, MSH6, MUYTH, NF2, PMS1, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TGFBR2, TP53, VHL)

☐ **PROSTATE*NOW*™ Hereditary Prostate Cancer Panel**
(*ATM, ATR, BARD1, BRCA1, BRCA2, BRIP1, CHEK2, EPCAM, FAM175A, FANCA, GEN1, HOXB13, HSD3B1, MLH1, MRE11A, MSH2, MSH6, NBN, PALB2, PMS2, RAD51C, RAD51D, TP53,* 223 SNP-BASED GRS)

Additional Genes Requested/or Mutation Specific Testing:

FOR PROVIDER

Please check all that apply

☐ Patient submitting for prior authorization with sample.
☐ Patient submitting for prior authorization without sample. Sample to be received: ____________
☐ ABN or Medicaid Waiver (if applicable)
☐ Patient Information & consent (required)
☐ Patient Insurance card (front & back)

____
Physician Signature (required)

PATIENT AUTHORIZATION

By signing this document, I authorize my provider to order this test. I understand authorization maybe required and is not a guarantee of payment by my insurance carrier. I understand that I may be contacted if there is an out-of-pocket payment.

______________________ ______________ ______________
Signature of Patient/Guardian (required) Date Phone Number

To view reports, please visit www.gopathlabs.com and click Online Reporting

A. NOTIFIER: ____________________

B. PATIENT NAME: ____________________

C. ID NUMBER: ____________________

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: If Medicare doesn't pay for D.________________________ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. ________________________ below.

D.	E. REASON MEDICARE MAY NOT PAY:	F. ESTIMATED COST
☐ **BRCA***NOW*® ☐ **BRCA***NOW*® Extended ☐ **LYNCH***NOW*™ ☐ **LYNCH***NOW*™ Extended ☐ **PROSTATE***NOW*™ Extended ☐ **DIABETES***NOW*™ ☐ **GENETICS***NOW*® **88 Gene Panel**	Patient does not meet Medicare coverage criteria	**$250**

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. ________________________ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: CHECK ONLY ONE BOX. WE CANNOT CHOOSE A BOX FOR YOU.

☐ **OPTION 1.** I want the D. listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D.________________________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the D. listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. ADDITIONAL INFORMATION:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. SIGNATURE: ______________________________ J. DATE: ____________________

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.