Foresight® Carrier Screen requisition form

myriad WOMEN'S HEALTH

INSTRUCTIONS

1. Collect the patient's sample by following the instructions in the Myriad kit.
2. Place this form in the box along with the sample.

Use: (One) Lavender top tube or OG-510. For simultaneous testing, submit a separate form for each patient.

Questions?
prenatalsupport@myriad.com
(888)-268-6795

180 Kimball Way
S. San Francisco, CA

PATIENT INFORMATION

Myriad will use this information to contact the patient via automatic e-mail, SMS and/or phone regarding payment, screen processing status and online results access, or as otherwise outlined in the Informed Consent document. By submitting this requisition, I confirm that I have obtained the patient's express authorization to be contacted by Myriad through any of these means.

Patient e-mail address

Patient mobile number

First name MI

Last name

Address

City State ZIP

Sex: ☐ Female ☐ Male

Date of birth ___/___/___

Ethnicity *Select all that apply.*

- ☐ Northern European *e.g. British, German*
- ☐ Southern European *e.g. Italian, Greek*
- ☐ French Canadian or Cajun
- ☐ Ashkenazi Jewish
- ☐ Other/Mixed Caucasian
- ☐ East Asian *e.g. Chinese, Japanese*
- ☐ South Asian *e.g. Indian, Pakistani*
- ☐ Southeast Asian *e.g. Filipino, Vietnamese*
- ☐ African or African American
- ☐ Hispanic
- ☐ Middle Eastern
- ☐ Native American
- ☐ Pacific Islander
- ☐ Unknown

CLINIC INFORMATION

Fax:

Ordering healthcare provider *Select one.*

☐

AUTHORIZATION

Healthcare provider statement of medical necessity

*By submitting this requisition, I confirm that I have obtained the patient's informed consent (**"Myriad Informed Consent"**) for the screening. **Furthermore,** I confirm that this Myriad screen is medically necessary for the patient. I understand that the definition of medical necessity may vary based on payer medical policy. I authorize the disease panel and the associated patient results and report to be amended in accordance with payer medical policy.*

Signature of healthcare provider

___/___/___

Date

This date will be deemed the date of service if an alternative collection date is not provided

AUTHORIZED REPRESENTATIVE

By providing the below contact, I confirm that the patient has expressly consented to Myriad sharing the patient's protected health information, including screening results and billing information, with the person listed upon request.

Name

Relationship to patient

GENETIC COUNSELOR

Genetic counselor *If applicable.*

PATIENT MRN

BILLING INFORMATION

Select one option

☐ **Option A: Bill to insurance** *Attach a copy of front and back of patient's insurance card.*

Policy owner's name

Relationship to insured:
☐ Self ☐ Spouse ☐ Child ☐ Other

Sex: ☐ Female ☐ Male

___/___/___
Date of birth

Authorization number (if obtained, please attach)

Insurance company name

Member ID number

Group number

☐ **Option B: Bill to patient**

Name of card holder

Card number

___/___
Expiration date CCV Billing ZIP

☐ **Option C: Bill to clinic**

Tests ordered will be processed and billed based on payer criteria.

MYRIAD FORESIGHT® CARRIER SCREEN

Place patient's Foresight Carrier Screen barcode or write here:

Use: *(One) Lavender top tube or OG-510*

___/___/___
Sample collection date (required)

Required information

Pregnant? ☐ Yes (Z34.90) ☐ No

Due date: ___/___/___

First pregnancy? ☐ Yes ☐ No

Egg/sperm donor? ☐ Yes ☐ No

Disease panel *Required. Select one.*

☐

☐ *Include fragile X (female only)*

Clinical indications *Required. Codes below are not exhaustive.*

- ☐ *Family history and/or partner positive screen: Z84.89*
- ☐ *Screening for genetic disease carrier status: Z31.430, Z31.440*
- ☐ *Family history of consanguinity: Z84.3*
- ☐ *Supervision, normal 1st pregnancy: Z34.00, Z34.01, Z34.02, Z34.03*
- ☐ *Supervision, other normal pregnancy: Z34.80, Z34.81, Z34.82, Z34.83*
- ☐ *Other genetic carrier status: Z14.8*
- ☐ *High-risk ethnicity: Z15.89*
- ☐ *Other ICD-10 codes:* ___

Describe relevant family history or prior testing *Required.*

Partner's information *A separate requisition must be completed for partner test. Provide at least 2 of the following 3 identifiers to combine results.*[1]

1. Name: ___
2. DOB: ___/___/___
3. Place partner's Foresight Carrier Screen barcode or write here:

[1] *By providing the partner's information, I certify that I have obtained each partner's consent to combine their results, and have advised each partner that both parties will have access to each other's test results. Combined results can only be generated if the physician is the same for both partners. Partner information may also be used for unmerged results.*

V4.0.RL