Test Requisition Form COMPLETE ENTIRE FORM TO AVOID DELAYS

PATHWAY GENOMICS®

ACCESSION NO. (LAB USE ONLY)

SPECIMEN ID PLACE BARCODE HERE

PATIENT INFORMATION

NAME (LAST, FIRST, MI)

PRIMARY ETHNICITY (CHOOSE ONE)
☐ AFRICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ DECLINE TO ANSWER

ADDRESS (STREET, CITY, STATE, ZIP)

DOB (MM/DD/YYYY)

SEX ☐ MALE ☐ FEMALE

PHONE

EMAIL

MEDICATIONS

ORDER AUTHORIZED BY

PHYSICIAN NAME

MEDICAL CREDENTIALS

NPI #

ADDRESS (STREET, CITY, STATE, ZIP)

FACILITY NAME

PHONE

FAX

SPECIMEN INFORMATION (REQUIRED)

DATE OF COLLECTION

TIME OF COLLECTION

SPECIMEN TYPE
☐ BUCCAL SWAB
☐ BLOOD (LAVENDER CAP)

EMAIL (IF APPLICABLE)

GENERAL HEALTH & WELLNESS

☐ CARDIAC DNA INSIGHT® (1710)	☐ *CARDIAC HEALTHY WEIGHT DNA INSIGHT® (1688)	☐ *GLUTEN FIT™ (2005)	☐ *HEALTHY WEIGHT DNA INSIGHT® (1534)
☐ *HEALTHY WOMAN DNA INSIGHT® (1525)	☐ *PATHWAY FIT® (1503)	☐ SKINFIT™ (2001)	

* **INCLUDES ONE DIET GUIDELINES REPORT AT NO ADDITIONAL COST:**

☐ STANDARD (1728) ☐ DAIRY FREE (1730) ☐ GLUTEN FREE (1652) ☐ PREGNANCY AND LACTATION (1363) ☐ VEGETARIAN (1729)

PHARMACOGENOMICS

☐ MENTAL HEALTH DNA INSIGHT® (1469)	☐ PAIN MEDICATION DNA INSIGHT® (1275)		

CARRIER SCREENING

☐ CARRIER STATUS DNA INSIGHT® (1687)			

PAYMENT OPTIONS (SIGNATURE REQUIRED)

☐ PATIENT PAY

☐ BILL INSURANCE
(ATTACH FRONT AND BACK COPY OF INSURANCE CARD, CHART NOTES)

FIRST AND LAST NAME OF FINANCIALLY RESPONSIBLE PARTY IF NOT PATIENT
(E.G. PATIENT IS A MINOR)

☐ INVOICE PRACTICE

INSURANCE COMPANY NAME

POLICY NUMBER / MEMBER ID

ICD-10 CODES FOR INSURANCE

Patient Acknowledgement and Authorization for Insurance Billing and Report Release: If I have provided my insurance information for direct insurance/3rd party billing: **I hereby authorize my insurance benefits to be paid directly to Pathway Genomics Corporation (Pathway) and authorize Pathway to release medical information concerning my testing, including upon request my genetic testing results, to my insurer and any business associate of insurer (TPB, TPA, etc.).** I authorize Pathway to be my Designated Representative for purposes of appealing any denial of health benefits. I understand that I am responsible for any amounts Pathway bills directly to me, including amounts that my insurer determines are my responsibility after calculating deductibles, co-payments and co-insurance due under my policy. I understand that I am legally responsible for sending Pathway any money received from my health insurance company for performance of this genetic test.

▶ Patient Signature _____ Date _____

ORDERING HEALTHCARE PROFESSIONAL (SIGNATURE REQUIRED)

Informed Consent and Statement of Medical Necessity: I hereby confirm that the test(s) are medically necessary for the treatment and/or plan of care for the patient. I further hereby confirm that the information has been supplied about genetic testing and that an appropriate Pathway informed consent has been signed by the patient and is on file with the ordering healthcare professional.

Did patient opt-out for the use of their sample for research purposes in the consent? ☐ Yes ☐ No ▶ Physician Signature _____ Date _____